"electronically transmitting or causing to be transmitted by means of wire communication in interstate commerce materially false and fraudulent forms **to file claims** for medical services and testing with both a federally funded health care program, Medicaid, and a private health care insurer, BC/BS." Appendix at App. 7 (emphasis added). The indictment further states that "in furtherance of this scheme to defraud, the defendant knowingly and willingly submitted false claims for allergy services whereby defendant routinely claimed that he performed more tests on children 24 months and younger than in fact were performed." Appendix at App. 7. Nowhere does the indictment mention specific patients, claim numbers, checks or specific visit dates. Also, the indictment never mentions the Coliseum Diagnostic Clinic. The only clinic mentioned is the Odessa Allergy Clinic. And, the indictment never alleges that Dr. Rana billed for procedures that were unnecessary, the indictment only alleges billing for tests not performed. At trial, however, this allegation became an important part of the Government's case.

The Government also set out to prove several different schemes in several different ways. It changed its theory of the case when it became apparent that the original theory was incorrect. The Government changed its theory to an allegation that Dr. Rana was aware of but did not correct a computer program malfunction that entered "96" as the number of allergy tests administered regardless of the number keyed in by his billing staff. The Government also added additional schemes; it alleged that Dr. Rana performed and billed children under two for more than a putative standard number of 24 tests (1SR7); and that Dr. Rana insisted an employee, a doctor, perform an x-ray that was medically unnecessary at the other clinic, the Coliseum Diagnostic Clinic. 11R3.

REASONS FOR GRANTING THE WRIT

This case warrants review for a number of important reasons. There is a lack of case law from the Circuit Courts of Appeal interpreting 18 U.S.C. §1347, more than nine years have elapsed since the passage of this statute and this important federal issue is overripe for settlement. There is also a sharp conflict within the few courts that have addressed the issue. The Fifth Circuit is the only Circuit that has addressed the issue in any depth and there is a sharp conflict within the Circuit. More importantly, the direction of the Fifth Circuit deviates from the apparent position of the Third Circuit in *U.S. v. Behmanshah*, 49 Fed.Appx. 372, 375 (3rd Cir. 2002) [unpublished] and the position of the District of Kansas, *U.S. v. Cooper*, 283 F.Supp.2d 1215 (D.Kan. 2003). Finally, the Fifth Circuit's decision in this case conflicts with the holding of this Court in *Richardson v. U.S.*, 526 U.S. 813, 119 S.Ct. 1707 (1999). The fact that Rana's opinion and *U.S. v. Kirkham*, 129 Fed.Appx. 61 (5th Cir. 2005), were not designated for publication while both opinions modify and explain *U.S. v. Hickman*, 331 F.3d 439 (5th Cir. 2003),[2] both create uncertainty[3] regarding the law concerning changing health care fraud and, given this Honorable

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[2] The Fifth Circuit opinion on appeal from remand in *Hickman* was vacated on the basis of this Court's opinion in *U.S. v. Booker*, 125 S.Ct. 738 (2005). *See Hickman v. U.S.*, 374 F.3d 275 (5th Cir. 2004), *cert. granted and judgment vacated on other grounds*, 124 S.Ct. 1043, 160 L.Ed.2d 1041 (2005).

[3] *See* Committee Note to proposed Rule 32.1 of the Federal Rules of Appellate Procedure:

> "Attorneys will no longer have to pick through the conflicting no-citation rules of the Circuits in which they practice, nor worry about being sanctioned or accused of unethical conduct for improperly citing an 'unpublished opinion'."

Court's practice of not granting certiorari in unpublished cases, denies this and other litigants in his situation, the Due Process Clause' guarantee of fundamental fairness, justice and liberty. The practice also hinders this Court's function as the ultimate authority concerning federal questions. Therefore, this Court should grant certiorari to also insure the proper functioning of the federal judiciary pursuant to its supervisory power under Rule 10(a) of the Supreme Court Rules.[4]

I. Given the split within the Fifth Circuit and with the Third Circuit as well as the near total lack of interpretive case law from other Circuits, whether it is proper to charge multiple completed executions of health care fraud in one count.

There is a severe lack of case law interpreting 18 U.S.C. §1347; this has been recognized numerous times by several of the Circuit Courts of Appeal, and there is a split within the few courts that have spoken in this area. In *U.S. v. Behmanshah*, 49 Fed.Appx. 372 (3rd Cir. 2002) [unpublished], the defendant was charged for multiple executions of health care fraud in a one count indictment, on appeal she argued that the charge was duplicitous. *U.S. v. Behmanshah*, 49 Fed.Appx. 372, 374 (3rd Cir. 2002) [unpublished]. The court recognized the lack of case law interpreting this statute noting, "determining whether a

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[4] The Court may grant a writ of certiorari in order to exercise its supervisory powers under 10(a) of the Supreme Court Rules.

"[T]he reasons the Court considers:

(a) a United States Court of Appeals . . . has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of the Court's supervisory power. . . ." Rule 10 of the Supreme Court Rules.

count charges multiple offenses requires a determination of the appropriate unit of prosecution for the pertinent offense, a determination that both defendant and the Government concede remained unresolved for § 1347 at the time of Behmanshah's trial." *U.S. v. Behmanshah*, 49 Fed.Appx. 372, 374 (3rd Cir. 2002) [unpublished]. Unfortunately, because the defendant had failed to raise her claims prior to appeal, the court only engaged in a plain error analysis and because of the lack of case law held that, "with this uncertainty in the law, the error if any occurred was not 'plain.'" *U.S. v. Behmanshah*, 49 Fed.Appx. 372, 374 (3rd Cir. 2002) [unpublished]. Thereafter, the court held that it need not decide what the proper unit of prosecution is for this statute and left the question open. *U.S. v. Behmanshah*, 49 Fed.Appx. 372, 375 (3rd Cir. 2002) [unpublished]. However, the court indicates that it would consider the indictment duplicitous but harmless since the accompanying mail fraud counts and jury instructions concerning unanimity "on each and every element" assured the court of the jury's unanimity concerning the acts upon which it relied to convict. *U.S. v. Behmanshah*, 49 Fed.Appx. 372, 374-375 (3rd Cir. 2002) [unpublished].

The Second Circuit has also recognized the lack of interpretation of §1347 noting, "case law interpreting the 1996 federal health care fraud statute is, so far as we can discover, virtually non-existent." *U.S. v. Lucien*, 347 F.3d 45, 48 (2nd Cir. 2003). This lack of interpretive case law is also apparent from the nationwide confusion over the proper method of charging this crime; an overview of the cases in which §1347 was charged reveals extensive differences on this issue. Many cases charge multiple executions in one count. *See U.S. v. Bobo*, 344 F.3d 1076 (11th Cir. 2003); *U.S. v. Baldwin*, 277 F.Supp.2d 67 (D.D.C. 2003); *U.S. v. Kaplan*, 2003 WL 22880914 (S.D.N.Y. 2003); *U.S. v.*

Lauersen, 2004 WL 1713816 (S.D.N.Y. 2004); *U.S. v. Barbera*, 2004 WL 2403868 (S.D.N.Y. 2004); *U.S. v. Augustine Medical, Inc.*, 2004 WL 256772 (D.Minn. 2004); *U.S. v. West*, 2003 WL 1119990 (E.D.Mich. 2003); *Chudry v. U.S.*, 2005 WL 1115363 (S.D.N.Y. 2005); *U.S. v. Vining*, 2000 WL 1015919 (S.D.N.Y. 2000); *U.S. v. Williams*, 355 F.Supp.2d 903 (N.D.Ohio 2005); *U.S. v. Nachamie*, 28 Fed.Appx. 13 (2nd Cir. 2001) [unpublished]; *U.S. v. Mitrione*, 357 F.3d 712 (7th Cir. 2004); *U.S. v. Concessi*, 38 Fed.Appx. 866 (4th Cir. 2002) [unpublished]; *U.S. v. Vehoski*, 67 Fed.Appx. 158 (3rd Cir. 2003) [unpublished]. While yet many other cases charge each execution of a scheme as a separate count. *See U.S. v. Singh*, 390 F.3d 168 (2nd Cir. 2004); *U.S. v. McGovern*, 329 F.3d 247 (1st Cir. 2003); *U.S. v. Heldeman*, 402 F.3d 220 (1st Cir. 2005); *U.S. v. Carlson*, 406 F.3d 529 (8th Cir. 2005); *U.S. v. Clark*, 26 Fed.Appx. 422 (6th Cir. 2001) [unpublished]; *U.S. v. Ware*, 282 F.3d 902 (6th Cir. 2002); *U.S. v. Raithatha*, 385 F.3d 1013 (6th Cir. 2004); *U.S. v. Elshingenty*, 78 Fed.Appx. 271 (4th Cir. 2003) [unpublished]; *U.S. v. Gomez*, 237 F.3d 238 (3rd Cir. 2000); *U.S. v. Goli*, 69 Fed.Appx. 338 (8th Cir. 2003) [unpublished]; *U.S. v. Cooper*, 283 F.Supp.2d 1215 (D.Kan. 2003); *U.S. v. Lazar*, 2004 WL 3142229 (W.D.Tenn. 2004); *U.S. v. Erhart*, 2002 WL 398835 (D.Minn. 2002); *U.S. v. Bentz*, 2005 WL 1130071 (D.Minn. 2005); *U.S. v. Daniels*, 159 F.Supp.2d 1258 (D.Kan. 2001); *U.S. v. Spiram*, 147 F.Supp.2d 914 (N.D.Ill. 2001); *U.S. v. Vasquez-Ruiz*, 136 F.Supp.2d 941 (N.D.Ill. 2001); *U.S. v. Mikos*, 2003 WL 22110948 (N.D.Ill. 2003). From these cases one can see that after simmering for more than nine years, this issue is overripe for settlement.

The only other court outside of the Fifth Circuit to decide whether each execution of a scheme to defraud health care is properly charged in separate counts is a Federal District Court case from the District of Kansas. In

U.S. v. Cooper, 283 F.Supp.2d 1215 (D.Kan. 2003), the defendants were indicted in a multiple count indictment with, *inter alia*, twelve counts of health care fraud. *U.S. v. Cooper*, 283 F.Supp.2d 1215, 1228 (D.Kan. 2003). Cooper argued that these counts were barred by the statute of limitations because the counts did not allege that the false claims were submitted before the period of limitations had expired. Cooper also contended that the crime was "executed" "by submitting false documents." *U.S. v. Cooper*, 283 F.Supp.2d 1215, 1230 (D.Kan. 2003). The court rejected this in holding that like bank fraud, the crime of health care fraud punishes executions of a scheme and execution occurs upon the payment of money, not upon the submission of the claims alone. *U.S. v. Cooper*, 283 F.Supp.2d 1215, 1231 (D.Kan. 2003). Therefore, since each count specifically identifies a check for payment of the false claims which issued within the five years preceding the indictment, there is no statute of limitations problem. *U.S. v. Cooper*, 283 F.Supp.2d 1215, 1231 (D.Kan. 2003). The court also addresses Cooper's claim that the counts are multiplicitous. It rejects this argument noting that health care fraud punishes executions of a scheme and that a "defendant may be charged for each execution of the scheme to defraud." *U.S. v. Cooper*, 283 F.Supp.2d 1215, 1231 (D.Kan. 2003). The court reasoned that the scheme consisted of submitting claims for medical equipment that was unnecessary or not providing and receiving payment for these claims. Thus, there was a separate payment on each claim and each payment resulted in a separate loss to the health benefit program. *U.S. v. Cooper*, 283 F.Supp.2d 1215, 1234 (D.Kan. 2003). Then, the court concluded that there was no multiplicity by indicting each payment separately. It cited this Court's statement in *Blockburger v. U.S.*, 284 U.S. 299, 52 S.Ct. 180, 76 L.Ed. 306 (1932), "If

successive impulses are separately given, even though all unite in swelling a common stream of action, separate indictments lie." *Blockburger v. U.S.*, 284 U.S. 299, 302, 52 S.Ct. 180, 76 L.Ed. 306 (1932) [quoting Wharton's Criminal Law, §34]. *U.S. v. Cooper*, 283 F.Supp.2d 1215, 1234 (D.Kan. 2003).

The Fifth and Third Circuits are the only Circuit Courts of Appeal that have directly attempted to determine the proper method of charging a violation of 18 U.S.C. §1347. Also, there is a split within the Fifth Circuit and with the Third Circuit and the Fifth Circuit's position in *Rana* on this issue. The direction that the Fifth Circuit is going is contrary to the apparent direction of the Third Circuit noted above in *U.S. v. Behmanshah* and very different from *U.S. v. Cooper* 283 F.Supp.2d 1215 (D.Kan. 2003), as well.

The first Fifth Circuit opinion that spoke in this area was *U.S. v. Hickman*, 331 F.3d 439 (5th Cir. 2003). Later, the Fifth Circuit modified its ruling in *Hickman* in the case of *U.S. v. Kirkham*, 129 Fed.Appx. 61 (5th Cir. April 11, 2005) [unpublished]. And, in Dr. Rana's case, the Fifth Circuit radically deviates from *Hickman*, *supra*. *U.S. v. Rana*, 129 Fed.Appx. 890 (5th Cir. April 28, 2005) [unpublished]. Appendix at App. 1.

Ms. Hickman argued that three of the thirty-two counts of health care fraud for which she was indicted were barred by the *Ex Post Facto* clause of the U.S. Constitution.[5] Thus, the court had to first determine the unit of prosecution for this offense and whether it was a continuing offense. *U.S. v. Hickman*, 331 F.3d 439, 445 (5th Cir. 2003). The court recognized that there was virtually no case law interpreting this statute and then decided that this statute was

[5] "No Bill of Attainder or *Ex Post Facto* shall be passed." Article I, Section 9, U.S. Constitution.

properly analogized to those cases interpreting bank fraud, stating, "although there is a paucity of case law interpreting this provision, its language and structure are almost identical to the bank fraud statute, 18 U.S.C. §1344." *U.S. v. Hickman*, 331 F.3d 439, 445 (5th Cir. 2003). Thereafter, the court looked to the case law interpreting §1344 and held that §1347 punishes individual completed executions of a scheme to defraud rather than acts in furtherance of the scheme, as in mail or wire fraud. *U.S. v. Hickman*, 331 F.3d 439, 445 (5th Cir. 2003). The court noted that defining what constitutes an "execution" of a given scheme is a fact intensive inquiry that may vary from case to case. *U.S. v. Hickman*, 331 F.3d 439, 446-447 (5th Cir. 2003). According to the Fifth Circuit, the nature of Hickman's scheme was to submit false claims to health insurers, the benefit was the money, the financial gain, rendered by the insurer to Hickman after each false claim was processed. *U.S. v. Hickman*, 331 F.3d 439, 446 (5th Cir. 2003). The court determined that the independence of the submission of each claim, even if grouped for efficiency, constituted an independent obligation to be truthful to the insurer. *U.S. v. Hickman*, 331 F.3d 439, 446 (5th Cir. 2003). Hickman's scheme was therefore, "in essence, a check-kiting scheme in the healthcare industry." *U.S. v. Hickman*, 331 F.3d 439, 446 (5th Cir. 2003). The court noted that with each claim Hickman owed a separate duty of candor and each claim was submitted separately and paid separately even if they were submitted as a group. Thus, in the case of *Hickman*, each act of fraud under 18 U.S.C. §1347 is executed, and therefore properly subject to a separate count, when an individual claim is submitted, processed and paid. *U.S. v. Hickman*, 331 F.3d 439, 446-447 (5th Cir. 2003).

The court then decided that because the three counts alleged that the schemes were fully executed before the effective date of the statute, they were barred by the *Ex Post Facto* clause. *U.S. v. Hickman*, 331 F.3d 439, 447 (5th

Cir. 2003). In reaching this decision the court in its footnotes 7 and 8 rejected the government's argument that health care fraud is a continuing offense that is not complete until the last false claim was submitted. It explained that it was rejecting the government's argument because the government alleged each false claim in individual counts, thus, belying its stated view that health care fraud was one continuing offense. It stated that if that were indeed the government's view, it may have charged all of the false claims in one count, [footnote 7]. It also rejected the government's argument because even though health care fraud is a continuing offense, this does not define each execution of a scheme [footnote 8]. Thus, the Fifth Circuit held that the *Ex Post Facto* clause barred the charging of individual executions of a scheme committed before the effective date of the statute. *U.S. v. Hickman*, 331 F.3d 439, 447 (5th Cir. 2003). In footnote 8 the court held:

> "The government's argument that health care fraud is a continuing offense is correct. . . . It is also inapplicable. A *single* scheme to defraud is a continuing offense until the offender has executed it." *U.S. v. Hickman*, 331 F. . 439, 447, n. 8 (5th Cir. 2003) (internal citation omitted) [emphasis in original].

Thus, *U.S. v. Hickman*, 331 F.3d 439, 447, n. 8 (5th Cir. 2003), holds that each execution is a completed crime and therefore should be charged separately. *See Hickman* indictments, Appendix at App. 21. Additionally, the court holds that health care fraud is a continuing offense only within each individual execution; it is not continuing from execution to execution even if the executions are part of the same overall scheme to defraud.

The Fifth Circuit next addressed this area of 18 U.S.C. §1347 in *U.S. v. Kirkham*, 129 Fed.Appx. 61 (5th Cir. 2005) [unpublished]. Appendix at App. 47. In this case, the defendants were charged in a one count indictment

with executing a scheme to defraud a health care benefit program; the scheme was alleged to have lasted from 1996 through 2000. *U.S. v. Kirkham*, 129 Fed.Appx. 61 (5th Cir. 2005) [unpublished]. In sharp contrast to the *Hickman* indictments (Appendix at App. 21), one part of the indictment listed 13 individual executions of the scheme. The *Kirkham* indictment gave no indication as to whether the government wished to focus on a particular execution or whether it was attempting to include them all within the count. *U.S. v. Kirkham*, 129 Fed.Appx. 61 (5th Cir. 2005) [unpublished]. Kirkham argued that under *Hickman*, this indictment was flawed because the government was required to charge each execution of the scheme in a separate count. *U.S. v. Kirkham*, *supra*. The court rejected this argument, in doing so the court attempted to portray its ruling as an interpretation of *Hickman* but in reality, *Kirkham* modifies the holding. The court says that while *Hickman* did indicate that a completed execution was the proper unit of prosecution, the opinion did not mandate that each execution be charged separately:

> "In *Hickman*, we held that the health care fraud statute, like the bank fraud statute, criminalized executions of schemes to defraud, in contrast to the mail and wire fraud statutes, which permit the government to charge a defendant for each act in furtherance of a scheme to defraud. We did *not* hold that the government *must* charge defendants with each separate execution of §1347, stating instead that, as a health care fraud may be executed several times, the government *could* charge each execution in a separate count." *U.S. v. Kirkham*, 129 Fed.Appx. 61, 67 (5th Cir. 2005) [unpublished] (emphasis in original).

However, the court also recognized that to avoid issues of duplicity, the government must "carefully craft its indictment to include only one execution of a scheme in a count." *U.S. v. Kirkham*, 129 Fed.Appx. 61 (5th Cir. 2005)

[unpublished]. The court noted that "section 1347 does not criminalize the scheme alone – the government must prove at least one execution of the scheme, and the indictment should specify which execution of the scheme will be used." Thereafter, the court looked at the indictment and noted that it,

> "[l]ists 13 allegedly fraudulent claims without singling out one particular claim as the one for which liability will be imposed. Had the indictment listed several transactions as examples of executions of the schemes but had also been 'carefully crafted' to identify one specific transaction that constituted [an] execution of the scheme and on which the jury must agree before convicting defendants, the indictment would not have been duplicitous; however, it did not do so." *U.S. v. Kirkham*, 129 Fed.Appx. 61 (5th Cir. 2005) [unpublished].

Finally, the court addressed the *ex post facto* based claim made by the *Kirkham* defendants. Kirkham argued that this clause was violated because the government presented evidence of conduct that took place before the August 1996 effective date of the statute. The court rejected this argument noting:

> "In *Hickman*, we held invalid the defendant's conviction on three specific counts under §1347 for violation of the *Ex Post Facto* clause. Although we noted that a scheme to commit health care fraud is a continuing offense, we found that these three counts charged behavior that had been fully executed before the effective date of the statute. With respect to continuing offenses in general, however, the *Ex Post Facto* clause is not violated by application of a statute to a continuing scheme that began before the effective date of a statute but continued thereafter.

> Unlike the *Hickman* indictment, the one-count indictment against Kirkham and Murphy did not charge them on or list any individual counts or executions of transactions that were fully executed before the effective date of the statute. In fact, all of the executions listed in the indictment involved transactions that took place well after August 1996, and each 'patient' who testified at trial was billed after 1998. There is no danger that defendants were convicted on the basis of their pre-enactment behavior." *U.S. v. Kirkham*, 129 Fed.Appx. 61, 75-76 (5th Cir. 2005) (footnotes omitted).

Thus, because the individual executions were all completed after the effective date of the statute there was no issue with the *ex post facto* clause.

The Fifth Circuit in *Rana* took a very different tack from its *Hickman* and *Kirkham* decisions; in a one page outline form opinion the court summarily rejected Dr. Rana's arguments and departed radically from its earlier opinion. As said above, Dr. Rana was charged in a one count indictment. The indictment contained only very general language describing a scheme to submit false claims for allergy tests on children; the indictment did not list any specific bills, claims or specific patients and it never made any mention at all of performing unnecessary tests at any other clinic. Appendix at App. 7. This last allegation, of performing unnecessary tests, became an important part of the Government's case at trial. During trial, the Government alleged several hundred executions of health care fraud committed over six years, at two different locations and in several very different ways. Dr. Rana was alleged to have performed and billed for unnecessary procedures at the Coliseum Diagnostic Clinic in 1997. He was also alleged to have, several years later, billed for allergy tests that were never performed at the Odessa Allergy Clinic on approximately 200 named patients. Dr.

Rana argued throughout the proceedings that the indictment was flawed and that the Government needed to have a separate count for each alleged execution of the scheme, even raising this before the Fifth Circuit in several different points of error. The court, however, rejected this contention. In the instant case, the Fifth Circuit does not explicitly define the scheme to defraud that Dr. Rana was alleged to have engaged in and what would constitute an execution of it. The schemes in both *Hickman* and *Kirkham* are very similar to the one in *Rana* and presumably it should have been charged in the same manner as in the *Hickman* indictments or the jury should have been directed to the false claim upon which the Government was relying for conviction.

In *Hickman*, the court noted that the nature of Hickman's scheme was to submit false claims to health insurers. The benefit was the money, the financial gain, rendered by the insurer to Hickman after each false claim was processed. *U.S. v. Hickman*, 331 F.3d 439, 446 (5th Cir. 2003). The court determined that the independence of the submission of each claim, even if grouped for efficiency, constituted an independent obligation to be truthful to the insurer and thus was a separate execution. *U.S. v. Hickman*, 331 F.3d 439, 446 (5th Cir. 2003). The scheme at work in *Hickman* is very similar to the one Dr. Rana was accused of perpetrating, thus, under both *Hickman* and *Kirkham* each false claim is an independent execution rather than "an act in furtherance" of the false claim submission and under *Hickman*, each claim should be subject to a separate count. Here, the Fifth Circuit held that the indictment was not duplicitous and was not flawed because "Rana billed for services not performed and billed for unnecessary services actually performed as part of his scheme to commit health care fraud. Each false claim was an act in furtherance of that scheme." *U.S. v. Rana*, 129 Fed.Appx. 890, 891 (5th Cir. 2005) [unpublished]. Appendix at App. 1. Thus, the Fifth Circuit is radically departing from its earlier holdings.

The Fifth Circuit, here, also deviates from its holding in *Kirkham*, in that it makes no mention of a requirement that the government identify a specific execution that it intends to rely upon in order to avoid issues with duplicity and non-unanimity. Here, in sharp contrast to the two Fifth Circuit cases above, the indictment did not specify any specific claims, bills or patients much less specify one in particular upon which the government would rely. The court in Dr. Rana's opinion only holds "the indictment was not duplicitous" with no further discussion. *U.S. v. Rana*, 129 Fed.Appx. 890, 892, (5th Cir. 2005) [unpublished].

Finally, the Fifth Circuit departs from its previous rulings about the nature of this crime as a continuing offense. Dr. Rana argued at trial and on appeal that several of the alleged executions were barred by the five year statute of limitations. 18 U.S.C. §3282. Following the rule from *Hickman*, two groups of offenses charged within count one of the superceding indictment should have been barred by the five year statute of limitations. Recall that in both *Hickman* and *Kirkham*, the court held that the offense was only continuing within a single execution,

> "The government's argument that health care fraud is a continuing offense is correct. . . . It is also inapplicable. A *single* scheme to defraud is a continuing offense until the offender has executed it." *U.S. v. Hickman*, 331 F.3d 439, 447, n. 8 (5th Cir. 2003) [internal citation omitted] (emphasis in original).

The first of the two groups of actions that are time barred is an allegation at the Coliseum Diagnostic Clinic in September of 1997 which was charged by expansion of the beginning date in the Superseding Indictment on March 17, 2004 [20R420-427], and for which the statute of limitations expired in September 2002. The Government itself admitted that the alleged unnecessary procedures

given would be time barred if it was severed from the other acts:

> "If those two counts [the Coliseum Diagnostic Clinic allegations and the Odessa Allergy Clinic allegations] were severed, then we would have to dismiss the Dr. Graham claim based on statute of limitations." 13R42.

It also admitted this on page 38, n. 3 of their appeal brief to the Fifth Circuit.

The second group consists of alleged falsified Medicaid claims submitted from the Odessa Allergy Clinic between January 1998, until January 20, 1999, for which the statute of limitations expired before the first indictment was filed on January 21, 2004. According to the Government's Trial Exhibit 1, 23 of the allegedly fraudulent claims have dates of service during 1998. Seventeen of these were claims to Medicaid and six of these were claims to Blue Cross/Blue Shield. According to Government's Trial Exhibit 25, 12 of the 17 Medicaid claims also had dates of payment before March 17, 1999. Lastly, there are six Blue Cross/Blue Shield claims with dates of service during 1998, but no evidence in the record showing the date of payment for these claims. Therefore, under the Fifth Circuit's ruling in both *U.S. v. Hickman*, 331 F.3d 430 (5th Cir. 2003) and *U.S. v. Kirkham*, 129 Fed.Appx. 61 (5th Cir. 2005) all these claims should be barred by the statute of limitations because they were fully executed more than five years before the indictment was issued. The Fifth Circuit summarily rejected this argument however, saying "the indictment did not include acts barred by the statute of limitations, because Rana was engaged in a continuous scheme to commit health care fraud." *U.S. v. Rana*, 129 Fed.Appx. 890, 892 (5th Cir. 2005) [unpublished].

Therefore, it appears there are three different methods of charging a violation of 18 U.S.C. §1347 within the

Fifth Circuit alone, and two of the three are different from the method used in the Third Circuit. Under *U.S. v. Hickman*, 331 F.3d 430 (5th Cir. 2003), each execution must be charged separately. Under *U.S. v. Kirkham*, 129 Fed.Appx. 61 (5th Cir. 2005), a single count can contain multiple examples of executions of health care fraud but the indictment must be "carefully crafted" to identify one particular execution, upon which the jury must agree. Lastly, in *U.S. v. Rana*, 129 Fed.Appx. 890 (5th Cir. 2005), the Fifth Circuit announced a third method of charging, different from both of its previous holdings. Here, the court allows hundreds of executions to be in one count and makes no mention of a requirement that the jury agree on any one specific execution to convict. The two latter holdings are also different than the holdings of the federal district court for the District of Kansas in *U.S. v. Cooper* 283 F.Supp.2d 1215, 1231 (D.Kan. 2003), and the Third Circuit as indicated above in *U.S. v. Behmanshah*, 49 Fed.Appx. 372 (3rd Cir. 2002) [unpublished].

This Honorable Court should grant certiorari to settle this important federal question and hold that separate executions of health care fraud must be charged in separate counts. This is the proper method of charging for several reasons, including the Sixth Amendment right of a unanimous jury verdict, due process issues related to notice and issues related to the inability to claim double jeopardy as a bar to future prosecution. Here, the joinder of the two distinct schemes and the joinder of the 257 separate executions of the alleged Medicaid fraud scheme at the Odessa Allergy Clinic violates Rana's right to a unanimous verdict. *U.S. v. Campbell*, 279 F.3d 392, 398 (2nd Cir. 2002); *U.S. v. Hood*, 210 F.3d 660, 662-663 (6th Cir. 2000).

> "While the Government can save a duplicitous indictment by electing on what offense it will proceed, the Government did not do so. Thus a general verdict, such as returned here, did not

> reveal whether the jury reached a unanimous verdict on each offense or whether the jury found appellant guilty of one offense or all." *U.S. v. Crisci*, 273 F.3d 235, 239 (2nd Cir. 2001).

Recently, this Court addressed the requirement of jury unanimity in the case of *Richardson v. U.S.*, 526 U.S. 813, 119 S.Ct. 1707 (1999). In this case, this Court was asked to decide whether a jury had to unanimously agree not only that the defendant committed some continuing series of violations, but also about which specific violations make up that continuing series. *Richardson v. U.S.*, 526 U.S. 813, 817-818, 119 S.Ct. 1707, 1710 (1999). This Court held that each violation must be unanimously agreed upon by the jury. Thus, where the government introduces evidence about more violations than are necessary the jury must unanimously agree as to which particular violations upon which it is finding guilt. *Richardson v. U.S.*, 526 U.S. 813, 824, 119 S.Ct. 1707, 1713 (1999). This decision was based upon an interpretation of the continuing criminal enterprise statute.

This Court states that its requirement "that each 'violation' here amounts to a separate element is consistent with a tradition of requiring juror unanimity where the issue is whether a defendant has engaged in conduct that violates the law." *Richardson v. U.S.*, 526 U.S. 813, 818-819, 119 S.Ct. 1707, 1710-1711 (1999). This ruling was also based on the breadth of the statute in that many diverse types of crimes fall under the definition of "violations" under the statute. *Richardson v. U.S.*, 526 U.S. 813, 819, 119 S.Ct. 1707, 1711 (1999).

In the instant case, counsel specifically objected that it would be difficult to divine which of the different schemes charged were the basis for the jury's finding of guilt in the verdict, 13R34, explaining the issue thus,

> "One juror might say, 'I think that maybe he violated that graph' – 'I believe Dr. Graham.' Another

> juror might say, 'I believe' – And we've got them all in one – that's the danger of duplicitous indictments. You don't know what the jury did." 13R39.

Counsel then noted that in the *U.S. v. Hickman*, 331 F.3d 439 (5th Cir. 2003), indictments, each patients' claim was charged in a separate count. Appendix at App. 21. He commented:

> "If you divide it up that way, there's not a danger, there's never a danger that the jury confused all of these people. You could have 12 jurors that each thought we did – because as he said,. . . . And he's saying, well, if we billed for 98 and only performed 97 on one occasion, we will have violated this count. We've got 12 people finding, you know, they've got 200 sure they could – . . . they could all find one bill that was for one test that wasn't performed – none of them the same. And that simply is not what I think fairness requires. And that's why – at least make them divide it up by patient per count like they did in Hickman." 13R39-40.

The trial court's charge to the jury did not help cure the problem because the court declined to instruct the jury that it must unanimously agree on the basis for their verdict. In its charge, the trial court cautioned the jurors to only consider the crime charged. 5R1013. It read the indictment verbatim. 5R1014-1017. It did not define the scheme to defraud but quoted the manner and means portion of the indictment stating that Rana electronically transmitted false claims for medical services to Medicaid and Blue Cross/Blue Shield. 5R1016. Then, adding confusion to the issue, the trial court also charged, "It is not necessary that the Government prove all of the details alleged in the indictment concerning the precise nature of the alleged scheme, or that the alleged scheme actually succeeded in defrauding someone." 5R1019. The trial court concluded its instructions stating that the foreperson should write the

unanimous answer of the jury in the space provided for Count One, either guilty or not guilty. 5R1023. However, the court declined to instruct the jurors that they must unanimously agree upon what basis they were convicting Rana.

Rana requested that the jury be charged:

> "Ms. Orr: . . . [T]hat the jury must unanimously agree that by – the means upon which, if any, false claims were filed with the health care benefit program, Medicaid or Blue Cross/Blue Shield, and – with respect to the Dr. Graham incident. And I know the Court has included an instruction on unanimity, but it's my position that it doesn't go far enough given the different – in the Defense's position the different charges contained within Count one.
>
> The Court: I'm going to decline to give that in the charge." 21R830.

Even were a court to permit conviction for a single scheme to defraud based upon several executions of the scheme charged within one count, *see Richardson v. U.S.*, 526 U.S. 813, 119 S.Ct. 1707 (1999), it would demand that the prosecution specify or the court require the jury to decide unanimously upon which of the executions of the scheme it was relying to convict. Unlike *Richardson*, the health care fraud statute is not a conspiracy statute and thus requires that only one scheme be charged in each count, not that a continuing series of crimes predicate the larger conspiracy offense of a continuing criminal enterprise.

The due process clause also requires notice of the charges and thus also requires that individual executions of a scheme to defraud be charged in separate counts. As this Court has noted "No principle of procedural due process is more clearly established than that notice of the specific charge, and a chance to be heard in a trial of the issues raised by that charge, if desired, are among the

constitutional rights of every accused in a criminal proceeding in all courts, state or federal." *Cole v. State of Ark.*, 333 U.S. 196, 201, 68 S.Ct. 514, 517 (1948). Here, the indictment was so general that Dr. Rana was unable to discern, until after the trial had started and the Government put on their case, with what he was charged. The only portion of the indictment that approaches a specific charge states "the defendant knowingly and willfully submitted false claims for allergy services whereby the defendant routinely claimed that he performed more tests on children twenty-four months and younger then (sic) he in fact were performed." Appendix at App. 5. As noted above, the indictment in this case makes no mention of specific patients or claims, and it never mentions the Coliseum Diagnostic Clinic nor that Dr. Rana was accused of billing for unnecessary tests.

In his pretrial motions, Rana complained that the indictment was so vague that it lent itself to constructive amendment. 1R211-217, 3R505. He further argued that he could not tell what the grand jury had charged, noting that Rana had a right to indictment by a grand jury. Counsel specifically noted that the indictment lacked an adequate description or definition of the alleged scheme to defraud. 13R5.[6] If this Court were to require that each execution be separated into an individual count as in *Hickman*, *Cooper* and *Behmanshah*, then every defendant would have adequate notice of what offense with which he was charged and there would be no potential for inadequate notice as in this case.

Lastly, this Court should require multiple counts for multiple executions of a scheme to defraud because to allow otherwise opens the door to double jeopardy issues. Numerous courts have recognized that one of the dangers

[6] Neither did the indictment contain any indication of the loss amounts for each execution of the scheme to defraud. 13R5.

of a duplicitous indictment is a lack of double jeopardy protection. *See* Charles A. Wright, Federal Practice and Procedure §142 (1999). In this case, the indictment and the general verdict are so vague that Dr. Rana is potentially subject to indictment again for the same acts of which the jury found him guilty in his trial. As noted above, there was evidence introduced at trial related to 257 instances of alleged false claims at the Odessa Allergy Clinic and several allegedly unnecessary procedures performed and submitted to Medicaid at the Coliseum Diagnostic Clinic. The mere introduction of this evidence at trial is not enough to protect Dr. Rana from indictment on one or more of these acts.

Therefore, this Court should require that individual executions of health care fraud be indicted in separate counts in order to avoid issues with unanimity, lack of notice and double jeopardy protection. In light of the split within and among the Circuits and the inconsistency of the *Rana* opinion with this Court's holding in *Richardson*, this Court should grant certiorari to settle this important federal question.

II. Given the split among the Circuit Courts of Appeal concerning the value of unpublished opinions, the Petitioner's right to due process, and the importance of a functioning judiciary, whether a Court of Appeals may side step its own precedence by choosing not to publish its opinion.

The Fifth Circuit panel that reviewed the judgment of the district court issued an unpublished opinion announcing its decision. Fifth Circuit Rule 47.5.4 provides that such unpublished opinions "are not precedent" and may only be cited as "persuasive" when accompanied by a copy of the case with a clear warning of its non-precedential value. As unpublished opinions do not carry the weight of

precedent, they are not typically seen as indicative of the law of the issuing Circuit. Because such opinions will rarely individually merit review by the United States Supreme Court, the unpublished status of an opinion renders that case effectively unreviewable.

By some estimates, as many as 80% of all opinions are issued unpublished and without precedential value. Administrative Office of the United States Courts, Judicial Business of the United States Courts 2001, tbl. S-3 (2001). While many of these unpublished opinions may be correctly decided and perfectly consistent with governing law, those that are not find themselves generally precluded from review and reform from the highest court in our land as a consequence of having been deemed "inconsequential." Every year, thousands of litigants are cast into this dark territory that covers nearly four-fifths the landscape of federal appeals. Such a system invites a capricious application of law from case to case, shielded from accountability. Additionally, unpublished, non-precedential opinions allow the Circuit Courts of Appeals to mask splits between and within the Circuits, effectively usurping the authority of this Court to harmonize the interpretation and application of law in the federal courts. In effect, the practice places opinions conflicting with precedent beyond this Court's supervisory power to assure the proper functioning of the federal judiciary.

Petitioner Rana's case is a prime example of the misuse of the non-precedential opinion. The case presents an important, unresolved question of federal law, yet the Fifth Circuit continues to issue inconsistent decisions on the matter, evading review and creating the appearance of erratic decisions through the use of unpublished, non-precedential opinions. In *Rana*, the Fifth Circuit's unpublished opinion holds that a person charged with health care fraud may be indicted with over 200 separate claim submissions in one count. *See U.S. v. Rana*, 129 Fed.Appx.

890, 891 (5th Cir. 2003). Rana is in conflict with the court's decision in *U.S. v. Hickman*, 331 F.3d 439 (5th Cir. 2003), which states that each claim submission for payment must be charged in a separate count, and that one execution of a health care fraud scheme may be charged in a single count. Thus, footnotes 7 and 8 in the *Hickman* opinion support Rana's contention that each of the 200 plus claims upon which the Government intended to rely for conviction must be charged in separate counts. In light of this apparent contradiction, the *Rana* opinion should have been published according to Fifth Circuit's own rules.

U.S. v. Kirkham, 129 Fed.Appx. 61 (5th Cir. 2005), should also have been published and concerns this important federal question. It modifies and explains *Hickman* by holding that the government may site several claim submissions in one count by way of example but must also elect the claim submission upon which it would rely for conviction.

Fifth Circuit Rule 47.5.1 sets forth a standard and criteria for determining whether a case should be published or not. The rule provides that cases decided on the basis of well-settled principles of law should not be published, however "opinions that may in any way interest persons other than the parties to a case should be published." The rule goes on to specifically provide that a case should be published if it:

> "(a) Establishes a new rule of law, alters or modifies an existing rule of law, or calls attention to an existing rule of law that appears to have been generally overlooked;
>
> (b) Applies an established rule of law to facts significantly different from those in previous published opinions applying the rule;
>
> (c) Explains, criticizes, or reviews the history of existing decisional or enacted law;

> (d) Creates or resolves a conflict of authority either within the circuit or between this circuit and another;
>
> (e) Concerns or discusses a factual or legal issue of significant public interest; or
>
> (f) Is rendered in a case that has been reviewed previously and its merits addressed by an opinion of the United States Supreme Court." Rule 47.5.1 of the Rules of the Fifth Circuit Court of Appeals.

The inconsistencies between *Rana*, *Hickman*, and *Kirkham*, may only logically be interpreted one of two ways: either the Fifth Circuit is modifying the existing rule in *Hickman* for the *Rana* and *Kirkham* decision, or the court is applying the rule in *Hickman* to facts in *Rana* and *Kirkham* which it views as significantly different from those in its previous published decisions. The former possibility places *Rana* squarely within 47.5.1(a), while the later falls clearly under 47.5.1(b). In either case, the decision would surely be of interest to other litigants facing this critical issue in a health care fraud prosecution. Therefore, not only does the use of an unpublished decision in this case deprive the Petitioner of fairness and access to the courts for redress of his grievances, but it also creates confusion among other litigants attempting to define the manner in which to properly charge health care fraud under 18 U.S.C. §1347.

Rule 47.5.1 proposes vague and outdated policy reasons for the non-publication of cases, stating "the publication of opinions that merely decide particular cases on the basis of well-settled principles of law imposes needless expense on the public and burdens the legal profession." The concerns expounded by the rule envision a paper glut that would make reporting impracticable and research impossible. While Rule 47.5.1's excuses for non-publication may have been persuasive in the age of paper and press, our contemporary system of largely electronic reporting and research renders

such concerns moot and archaic. While economy may demand that not every case be included in the jurisdiction's official reporter, those unpublished cases may be readily found at relatively little expense in numerous online legal and free public databases, as well as, the Federal Appendix. Additionally, this rationale supporting non-publication of certain cases does not extend to denying these cases precedential value. To deny certain cases their place in the grand scheme of *stare decisis* fearing an inflation of the case reports, is to disregard the function of the federal judiciary. If an opinion tracks well settled points of law, no harm can come of allowing its citation before the court that decided it. If it does not, the courts should explain their departure.

The Petitioner brings before this Court a case typical of the misuse of non-precedential opinions by the Courts of Appeal. The Fifth Circuit in *Rana* and *Kirkham* creates confusion and disparity within the Fifth Circuit Court of Appeals and other jurisdictions relying upon the case[7] as persuasive authority. It also leaves unanswered an important federal question regarding the proper way in which to indict health care fraud under the health care fraud statute.

The Fifth Circuit has had a history of using the unpublished-non-precedential decision rule in order to achieve results side stepping precedent in cases where following the law of the Fifth Circuit would provide relief to the litigant. *See Williams v. Dallas Area Rapid Transit*, 256 F.3d 260 (2001) [Smith, J., dissenting from denial of rehearing *en banc*].

The Fifth Circuit is not the only court that has followed this practice. Commentators have written that the use of unpublished opinions in the Courts of Appeal

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[7] *Kirkham* is cited by Westlaw and Lexis as distinguishing and explaining *Hickman* even though the case is unpublished.

deprives litigants of the same fair consideration of their appeal as those published receive. *See* Boggs & Brooks, *Unpublished Opinions & the Nature of Judicial Precedent*, 4 Green Bag 2d 17 (Fall 2000) [discussing specifically the effect of unpublished opinions and judicial consistency]. *See also* Polly J. Price, *Precedent and Judicial Power After the Founding*, 42 B.C.L. Rev. 81 (Dec. 2001) [proposing an interpretation of Article III, United States Constitution, that "affirms the view that judicial power includes a doctrine of precedent, without relying solely upon an originalist interpretation."); Lance A. Wade, *Honda Meets Anastasoff: The Procedural Due Process Argument Against Rules Prohibiting Citation to Unpublished Judicial Decisions*, 42 B.C.L. Rev. 695 (May 2001). *See generally*, Kelso and Weinstein, *A White Paper on Unpublished Opinions of the Court of Appeal*, Appellate Process Task Force (March 2001), [http://www.courtinfo.ca.gov/reference/documents/unpub.pdf], August 16, 2005, Judicial Council of California; Merritt and Burdney, *Stalking Secret Law: What predicts publication in the United States Court of Appeals*, 54 Vand.L.Rev. 71 (2001); *Anastasoff v. U.S.*, 223 F.3d 898 (8th Cir. 2000), *vacated as moot*, 235 F.3d 1054 (8th Cir. 2000) [*en banc*].

The unavailability of the courts to some appellate litigants in the generation of unpublished opinions that are inconsistent with Circuit precedent create a lack of confidence in the availability and integrity of our judicial process. Consider the litigant who seeks justice in the federal courts only to have her attorney inform her that she may not rely on a previous case that is very much on point because it remains, unfortunately, unpublished. Or, worse yet, she should proceed to disposition only to find she has no practical access to the Highest Court because her case was not blessed with publication.

Publication, citation, and precedent rules vary widely amongst the Circuit Courts. The other Circuit Courts of

Appeal have similar rules regarding publishing opinions. Some Circuits favor publication while others establish a presumption against publication. *See* D.C. Cir. Rule 14(a); First Circuit Rule 36.1; Fifth Circuit Rule 47.5.1 [favoring publication]. *See also* Second Circuit Rule 0.23; Third Circuit IOP 5.5.1; Fourth Circuit IOP 36.4; Sixth Circuit Rule 53(a); Eighth Circuit app. I; Ninth Circuit Rule 36-2; Tenth Circuit Rule 36.1; Eleventh Circuit IOP Opinions, Rule 26 of the Federal Rules of Appellate Procedure; Federal Circuit Rule 47.8. And, each Circuit treats the precedential value of unpublished opinions somewhat differently leading to confusing results. For example, the Eleventh Circuit has cited *Rana* as indicative of the Fifth Circuit's position concerning resentencing after *Booker*,[8] while a litigant actually before the Fifth Circuit would not be able to cite to the *Rana* decision as such an authority. *See U.S. v. King*, 414 F.3d 1329 (11th Cir. 2005).

Such differing views on matters of publication and precedent have led the Committee on Rules of Practice and Procedure of the U.S. Courts to unanimously recommend to the Judicial Conference of the United States the approval of Proposed Rule of Appellate Procedure 32.1, [http://www.uscourts.gov/rules/], August 16, 2005. Proposed Rule 32.1 would disallow restrictions on citing unpublished opinions.[9] However, the proposed rule does not address the problem present in *Rana* as it would not require the Circuit Courts to consistently invest their opinions with the force of precedent.[10] This is especially important in *Rana* where the opinion strays from established law.

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[8] *U.S. v. Booker*, 125 S.Ct. 738 (2005).

[9] Text of Proposed Rule and Advisory Committee notes available at: www.uscourts.gov/rules/app0803.pdf.

[10] Petitioner requested rehearing *en banc* and feels that he was denied relief in part because his opinion was unpublished.

By choosing which cases to publish and which to refrain from publishing, the Fifth Circuit and other Circuit Courts of Appeal create a body of unreviewable law, masking splits between the Circuits and dispensing disparate forms of justice. Petitioner urges the Court to consider this important federal question and take action to reclaim its power to review the decisions of the Circuit Courts of Appeal and control the judicial function of Federal Judiciary.

CONCLUSION

There is a lack of case law from the Circuit Courts of Appeal and sharply conflicting case law where it does exist, on the important federal question of the interpretation of 18 U.S.C. §1347. Additionally, the Courts of Appeal widespread and ongoing practice of sidestepping review and consistent judicial reasoning through the use of unpublished, non-precedential decisions undermines the Court's essential supervisory powers and litigants' rights to due process. For the foregoing reasons, Dr. Rana respectfully moves this Court to grant review of this matter.

Respectfully submitted,

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IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 04-50791

UNITED STATES OF AMERICA,

Plaintiff-Appellee,

versus

ARTHUR NIAZ RANA,

Defendant-Appellant.

Appeal from the United States District Court
for the Western District of Texas
(USDC No. M-04-CR-003)

(Filed April 28, 2005)

Before REAVLEY, JONES, and GARZA, Circuit Judges.

PER CURIAM:*

For the following reasons we uphold the conviction, and we vacate and remand the case for resentencing:

1. Rana's various criminal acts were not improperly joined for trial, and the district court did not abuse its discretion by refusing to sever the allegations. *See United States v. Hickman*, 331 F.3d

* Pursuant to 5TH CIR. R. 47.5, the Court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5TH CIR. R. 47.5.4.

439, 446-47 & nn. 7-8 (5th Cir. 2003). Rana billed for services not performed and billed for unnecessary services actually performed as part of his scheme to commit health care fraud. Each false claim was an act in furtherance of that scheme. *Id.* at 446 & n.7. Likewise, Rana was not convicted on a less than unanimous verdict, and the indictment was not duplicitous. *Id.* at 443 and 446.

2. The government did not constructively amend the indictment by offering evidence that Rana performed and billed for unnecessary medical procedures in addition to offering evidence that Rana fraudulently billed for procedures that were never actually performed. The indictment referred to the elements of the charged offense generally and also mentioned specific instances of charging the health care programs for allergy tests Rana never performed. Rana claims that the government's introduction of testimony relating to other, medically unnecessary tests (in addition to evidence relating to the allergy tests Rana never performed at all) constituted a variance. However, the introduction of additional evidence referencing a separate fraudulent act does not mean that Rana was tried for anything beyond the specific charges presented in the indictment returned by the grand jury, or that Rana lacked sufficient notice of the charges against him. Any error was harmless. *See Stirone v. United States*, 361 U.S. 212, 217-18 (1960); *United States v. Martino*, 648 F.2d 367, 382 (5th Cir. 1981) (rejecting defendant's claim of variance where the government indicted on only one count of conspiracy and presented evidence of multiple conspiracies at trial).

3. The evidence was sufficient to support the jury's guilty verdict. Rana admitted that he billed for more allergy tests than he actually performed and

that he performed unnecessary medical procedures, and the government provided evidence that the overbilling was not merely due to clerical or computer errors. The government provided evidence that Rana was aware that he routinely billed for 96 allergy tests, no matter how many tests were actually performed. Because Rana targeted Medicaid, his scheme to commit health care fraud affected interstate commerce. *See Hickman*, 331 F.3d at 444.

4. The indictment did not include acts barred by the statute of limitations, because Rana was engaged in a continuous scheme to commit health care fraud. *Id.* at 445-46.

5. Rana argues that the district court erred by allowing into evidence summary charts without requiring the government to furnish the underlying data used to create the charts; however, after looking at all of the evidence, the district court found that the government had turned over all of the underlying data. Rana also argues that the summary charts were flawed or incomplete due to (1) clerical errors in the summary charts, (2) patients' information being redacted, and (3) the fact that the charts could not prove that the services billed for were not actually performed. The clerical errors in the charts may have affected the weight of the evidence, but they did not render the evidence inadmissible. Some of the patients' information was redacted to ensure the patients' privacy when the evidence was presented to the jury, but Rana had all of the redacted information. Finally, the summary charts were not offered to prove that Rana failed to perform the services for which he billed; they merely summarized Rana's billing history. The government offered sufficient evidence to prove that Rana had not performed the services,

including Rana's own admissions. We hold that the district court did not abuse its discretion by admitting the summary charts into evidence. *See United States v. Smyth*, 556 F.2d 1179, 1184 (5th Cir. 1977).

6. It was also not an abuse of discretion for the government to exclude Rana's hearsay evidence in the form of a note allegedly written by a former employee taking blame for billing errors that occurred at the clinic. *Id.*

7. The government did not engage in misconduct by questioning the authenticity of an obviously altered document offered into evidence by Rana. The district court noted that the date on which the document was purported to be created was three weeks after the date on which the document was offered into evidence, so there was some basis for the government's allegations.

8. Finally, in light of *United States. v. Booker*, ___ U.S. ___, 125 S. Ct. 738, 750 (2005), we vacate and remand the case for resentencing, because the district court and not the jury determined the amount of restitution and loss, which was then used to calculate Rana's sentence.

The conviction is AFFIRMED; the sentence is VACATED and the case is REMANDED.

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 04-50791

UNITED STATES OF AMERICA

Plaintiff-Appellee

v.

ATHAR NIAZ RANA

Defendant-Appellant

Appeal from the United States District Court for the Western District of Texas, Midland

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ON PETITION FOR REHEARING AND REHEARING EN BANC

(Filed May 25, 2005)

(Opinion 4/28/05, 5 Cir., ___, ___ F.3d ___)

Before REAVLEY, JONES, and GARZA, Circuit Judges.

PER CURIAM:

(X) The Petition for Rehearing is DENIED and no member of this panel nor judge in regular active service on the court having requested that the court be polled on Rehearing En Banc, (FED. R. APP. P. and 5TH CIR. R. 35) the Petition for Rehearing En Banc is also DENIED.

( ) The Petition for Rehearing is DENIED and the court having been polled at the request of one of the members of

the court and a majority of the judges who are in regular active service not having voted in favor, (FED. R. APP. P. and 5TH CIR. R. 35) the Petition for Rehearing En Banc is also DENIED.

( ) A member of the court in active service having requested a poll on the reconsideration of this cause en banc, and a majority of the judges in active service not having voted in favor, Rehearing En Banc is DENIED.

ENTERED FOR THE COURT:

/s/ Thomas M. Reavley
United States Circuit Judge

SEALED

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
MIDLAND-ODESSA DIVISION

UNITED STATES OF AMERICA,	**CRIMINAL NO. MO-04-CR-003**
Plaintiff,	**INDICTMENT**
V.	**[Vio:Count 1:18 USC 1347**
ATHAR NIAZ RANA,	**(Health Care Fraud)]**
Defendant.	

COUNT ONE
[18 U.S.C. §§ 1347, 2]

(Filed Jan. 21, 2004)

Introduction

1. The DEFENDANT, a physician-internist, has organized, owned, operated, managed, and offered medical services at the ODESSA ALLERGY CLINIC (the CLINIC) located in Odessa, Texas, during all times relevant to this indictment.

2. The DEFENDANT transmitted or caused to be transmitted by means of wire communication in interstate commerce materially false and fraudulent health care insurance claim forms to file claims for medical services and testing with both federally-funded health care programs such as Medicaid and private health care insurers such as Blue Cross/Blue Shield. Medicaid is designed to provide medical services, medical equipment and supplies to low income and indigent individuals who qualify under the Social Security Act. The Medicaid program authorizes

appropriations to participating states so the states may furnish reimbursement for covered medical services. All of these programs, both public and private insurers, provided their respective manuals, bulletins, revisions, and supplements thereto, to medical service providers to explain the propriety of billing practices and billing codes. These manuals, bulletins, revisions, and supplements described requirements, terms, limits, and claims procedures of the respective program.

3. The materially false and fraudulent electronic claim forms submitted for payment by the **DEFENDANT** were submitted pursuant to an electronic claim agreement with Medicaid and Blue Cross/Blue Shield and other insurance carriers and signed by the **DEFENDANT** certifying that all claims made by the **DEFENDANT** were true and the alleged services rendered and medical tests supposedly performed were medically necessary. This electronic claim form describes, among other things, the services provided to the patient, the symptoms or diseases suffered by the patient, and identifies the medical professional providing the services.

4. Both federally-funded and private insurers require medical diagnostic codes with the designation "ICD-9" codes to be included on electronic claim forms. These diagnostic codes are used by physicians to describe their patients' symptoms or diseases.

4. Both federally-funded and private insurers require medical treatment codes with the designation "CPT" codes to be included on the electronic claim forms. These treatment codes are used to describe the services provided by the physician.

5. The electronic claim forms submitted for payment by the **DEFENDANT** were electronically transmitted or caused to be transmitted by means of wire communication in interstate commerce with both the federally-funded health care insurance programs and private health care insurers. For example, all electronic claims filed with the State of Texas Medicaid program, which is federally funded, must be processed through a clearinghouse in the State of Michigan before it is transmitted to the Texas Medicaid program in Austin, Texas, in the Western District of Texas.

6. An "antigen" is any substance that can stimulate the production of antibodies; to wit, an "antigen" is a substance that can produce an allergic reaction in an individual.

Health Care Fraud

Beginning on or about January 1, 1998, and continuing to on or about May 28, 2003, in the Western District of Texas, the Eastern District of Michigan, and elsewhere, the **DEFENDANT**,

ATHAR NIAZ RANA,

aided and abetted by others, knowingly and willfully executed and attempted to execute a scheme and artifice to defraud any health care benefit program, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, any of the money and property owned by, and under the custody or control of, any health care benefit program in connection with the delivery and payment for health care benefits, items, and services.

Manner and Means

1. Beginning on or about January 1, 1998, and continuing to on or about May 28, 2003, in the Western District of Texas, the Eastern District of Michigan, and elsewhere, the **DEFENDANT** devised a scheme and artifice to defraud federally-funded and private health care insurers by electronically transmitting or causing to be transmitted by means of wire communication in interstate commerce materially false and fraudulent forms to file claims for medical services and testing with both federally-funded health care programs such as Medicaid, and private health care insurers such as Blue Cross/Blue Shield.

2. In furtherance of this scheme to defraud, the **DEFENDANT** knowingly and willfully submitted false claims for allergy services whereby the **DEFENDANT** routinely claimed that he performed more tests on children 24 months and younger then he [sic] in fact were performed.

3. The **DEFENDANT** profited and attempted to profit by this scheme and artifice to defraud the federally-funded and private health care insurers by submitting or causing to be submitted materially false and fraudulent electronic claim forms for medical services and testing by means of wire communication in interstate commerce. During the time frame specified, the **DEFENDANT** submitted these false claims for reimbursement for these tests totaling over $83,000 to Medicaid and Blue Cross/Blue Shield.

In violation of Title 18, United States Code, Sections 1347 and 2.

NOTICE OF UNITED STATES OF AMERICA'S DEMAND FOR FORFEITURE

I.

Money Judgment

[Title 18 U.S.C. § 1347, and subject to forfeiture pursuant to Title 18 U.S.C. § 982(a)(7), and 982(b)(1)]

As a result of the foregoing criminal violations as set forth in Count One (1), **DEFENDANT ATHAR NIAZ RANA**, shall forfeit to the United States of America, pursuant to Title 18 U.S.C. §§ 982(a)(7), and 982(b)(1) for violations of Title 18 U.S.C. § 1347, any and all property, real or personal, involved in the aforestated offense wherein **DEFENDANT ATHAR NIAZ RANA**, did obtain, use or intend to use:

> Any property, real or personal, which constitutes or is derived, directly or indirectly, from the gross proceeds traceable to the commission of the offense;

thereby making **DEFENDANT ATHAR NIAZ RANA's** right, title and interest in said property forfeitable to the United States of America, and all property traceable to such property, including but not limited to the following:

> **A Forfeiture Money Judgment in the amount of approximately TWENTY-SIX THOUSAND FOUR HUNDRED FORTY-FIVE DOLLARS FORTY-FIVE CENTS ($26,445.45) and any interest and proceeds traceable thereto, in that such sum in aggregate is property which was involved in the aforestated offense(s) or is traceable to such property.**

All in violation of Title 18 U.S.C. § 1347, and subject to forfeiture pursuant to Title 18 U.S.C. §§ 982(a)(7) and 982(b)(1).

II.

Substitute Assets
[Title 18 U.S.C. § 982(b)(1), Referring to: Title 21 U.S.C. § 853(p)]

If any of the personal properties described above as being subject to forfeiture, pursuant to Title 18 U.S.C. §§ 982(a)(7), and 982(b)(1), as a result of any act or omission of **DEFENDANT ATHAR NIAZ RANA**,

a. cannot be located upon the exercise of due diligence;

b. has been transferred or sold to, or deposited with, a third person;

c. has been placed beyond the jurisdiction of the Court;

d. has been substantially diminished in value; or

e. has been commingled with other property which cannot be subdivided without difficulty;

it is the intent of the United States of America to seek forfeiture of any other property of said **DEFENDANT ATHAR NIAZ RANA**, individually as related to any of the aforementioned personal property, and any other properties of said **DEFENDANT ATHAR NIAZ RANA**, up to the value of the aforementioned said sum, as listed in the Money Judgement above, pursuant to the substitute

asset provision of Title 18 U.S.C. § 982(b)(1), *See* Title 21 U.S.C. § 853(p).

–All in violation of Title 18 U.S.C. § 1347, and subject to forfeiture pursuant to Title 18 U.S.C. §§ 982(a)(7), and 982(b)(1), *See* Title 21 U.S.C. § 853(p).

A TRUE BILL

/s/ Roger T. Elliott
FOREPERSON OF THE
GRAND JURY

JOHNNY SUTTON
United States Attorney

By: /s/ Mark Roomberg
MARK T. ROOMBERG
Assistant United States Attorney

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
MIDLAND-ODESSA DIVISION

UNITED STATES OF AMERICA,	**CRIMINAL NO. MO-04-CR-03S**
Plaintiff,	**SUPERSEDING INDICTMENT**
V.	**[Vio:Count 1:18 USC 1347**
ATHAR NIAZ RANA,	**(Health Care Fraud)]**
Defendant.	

THE GRAND JURY CHARGES:

COUNT ONE
[18 U.S.C. §§ 1347, 2]

(Filed Mar. 17, 2004)

Introduction

1. The **DEFENDANT**, a physician-internist, has organized, owned, operated, managed, and offered medical services at the ODESSA ALLERGY CLINIC (the CLINIC) located in Odessa, Texas, during all times relevant to this indictment.

2. The **DEFENDANT** transmitted or caused to be transmitted by means of wire communication in interstate commerce materially false and fraudulent health care insurance claim forms to file claims for medical services and testing with both federally-funded health care programs such as Medicaid and private health care insurers such as Blue Cross/Blue Shield. Medicaid is designed to provide medical services, medical equipment and supplies to low income and indigent individuals who qualify under the Social Security Act. The Medicaid program authorizes

appropriations to participating states so the states may furnish reimbursement for covered medical services. All of these programs, both public and private insurers, provided their respective manuals, bulletins, revisions, and supplements thereto, to medical service providers to explain the propriety of billing practices and billing codes. These manuals, bulletins, revisions, and supplements described requirements, terms, limits, and claims procedures of the respective program.

3. The materially false and fraudulent electronic claim forms submitted for payment by the **DEFENDANT** were submitted pursuant to an electronic claim agreement with Medicaid and Blue Cross/Blue Shield and other insurance carriers and signed by the **DEFENDANT** certifying that all claims made by the **DEFENDANT** were true and the alleged services rendered and medical tests supposedly performed were medically necessary. This electronic claim form describes, among other things, the services provided to the patient, the symptoms or diseases suffered by the patient, and identifies the medical professional providing the services.

4. Both federally-funded and private insurers require medical diagnostic codes with the designation "ICD-9" codes to be included on electronic claim forms. These diagnostic codes are used by physicians to describe their patients' symptoms or diseases.

4. [sic] Both federally-funded and private insurers require medical treatment codes with the designation "CPT" codes to be included on the electronic claim forms. These treatment codes are used to describe the services provided by the physician.

5. The electronic claim forms submitted for payment by the **DEFENDANT** were electronically transmitted or caused to be transmitted by means of wire communication in interstate commerce with both the federally-funded health care insurance programs and private health care insurers. For example, all electronic claims filed with the State of Texas Medicaid program, which is federally funded, must be processed through a clearinghouse in the State of Michigan before it is transmitted to the Texas Medicaid program in Austin, Texas, in the Western District of Texas.

6. An "antigen" is any substance that can stimulate the production of antibodies; to wit, an "antigen" is a substance that can produce an allergic reaction in an individual.

Health Care Fraud

Beginning on or about September 1, 1997, and continuing to on or about May 28, 2003, in the Western District of Texas, the Eastern District of Michigan, and elsewhere, the **DEFENDANT**,

ATHAR NIAZ RANA,

aided and abetted by others, knowingly and willfully executed and attempted to execute a scheme and artifice to defraud any health care benefit program, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, any of the money and property owned by, and under the custody or control of, any health care benefit program in connection with the delivery and payment for health care benefits, items, and services.

Manner and Means

1. Beginning on or about September 1, 1997, and continuing to on or about May 28, 2003, in the Western District of Texas, the Eastern District of Michigan, and elsewhere, the **DEFENDANT** devised a scheme and artifice to defraud federally-funded and private health care insurers by electronically transmitting or causing to be transmitted by means of wire communication in interstate commerce materially false and fraudulent forms to file claims for medical services and testing with both federally-funded health care programs such as Medicaid, and private health care insurers such as Blue Cross/Blue Shield.

2. In furtherance of this scheme to defraud, the **DEFENDANT** knowingly and willfully submitted false claims for allergy services whereby the **DEFENDANT** routinely claimed that he performed more tests on children 24 months and younger then he [sic] in fact were performed.

3. The **DEFENDANT** profited and attempted to profit by this scheme and artifice to defraud the federally-funded and private health care insurers by submitting or causing to be submitted materially false and fraudulent electronic claim forms for medical services and testing by means of wire communication in interstate commerce. During the time frame specified, the **DEFENDANT** submitted these false claims for reimbursement for these tests totaling over $83,000 to Medicaid and Blue Cross/Blue Shield.

In violation of Title 18, United States Code, Sections 1347 and 2.

NOTICE OF UNITED STATES OF AMERICA'S DEMAND FOR FORFEITURE

I.

Money Judgment

[Title 18 U.S.C. § 1347, and subject to forfeiture pursuant to Title 18 U.S.C. § 982(a)(7), and 982(b)(1)]

As a result of the foregoing criminal violations as set forth in Count One (1), **DEFENDANT ATHAR NIAZ RANA**, shall forfeit to the United States of America, pursuant to Title 18 U.S.C. §§ 982(a)(7), and 982(b)(1) for violations of Title 18 U.S.C. § 1347, any and all property, real or personal, involved in the aforestated offense wherein **DEFENDANT ATHAR NIAZ RANA**, did obtain, use or intend to use:

> Any property, real or personal, which constitutes or is derived, directly or indirectly, from the gross proceeds traceable to the commission of the offense;

thereby making **DEFENDANT ATHAR NIAZ RANA's** right, title and interest in said property forfeitable to the United States of America, and all property traceable to such property, including but not limited to the following:

> **A Forfeiture Money Judgment in the amount of approximately TWENTY-SIX THOUSAND FOUR HUNDRED FORTY-FIVE DOLLARS AND FORTY-FIVE CENTS ($26,445.45) and any interest and proceeds traceable thereto, in that such sum in aggregate is property which was involved in the aforestated offense(s) or is traceable to such property.**

All in violation of Title 18 U.S.C. § 1347, and subject to forfeiture pursuant to Title 18 U.S.C. §§ 982(a)(7) and 982(b)(1).

II.

Substitute Assets
[Title 18 U.S.C. § 982(b)(1), Referring to: Title 21 U.S.C. § 853(p)]

If any of the personal properties described above as being subject to forfeiture, pursuant to Title 18 U.S.C. §§ 982(a)(7), and 982(b)(1), as a result of any act or omission of **DEFENDANT ATHAR NIAZ RANA**,

a. cannot be located upon the exercise of due diligence;

b. has been transferred or sold to, or deposited with, a third person;

c. has been placed beyond the jurisdiction of the Court;

d. has been substantially diminished in value; or

e. has been commingled with other property which cannot be subdivided without difficulty;

it is the intent of the United States of America to seek forfeiture of any other property of said **DEFENDANT ATHAR NIAZ RANA**, individually as related to any of the aforementioned personal property, and any other properties of said **DEFENDANT ATHAR NIAZ RANA**, up to the value of the aforementioned said sum, as listed in the Money Judgement above, pursuant to the substitute

asset provision of Title 18 U.S.C. § 982(b)(1), *See* Title 21 U.S.C. § 853(p).

All in violation of Title 18 U.S.C. § 1347, and subject to forfeiture pursuant to Title 18 U.S.C. §§ 982(a)(7), and 982(b)(1), *See* Title 21 U.S.C. § 853(p).

A TRUE BILL

/s/ Roger T. Elliott
FOREPERSON OF THE
GRAND JURY

JOHNNY SUTTON
United States Attorney

By: /s/ Mark T. Roomberg
MARK T. ROOMBERG
Assistant United States Attorney

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

UNITED STATES OF AMERICA	§	
	§	
V.	§	Cr.H-01-376
	§	
JOYCE LEE HICKMAN	§	

INDICTMENT

(Filed Apr. 8, 2004)

THE GRAND JURY CHARGES THAT:

A. INTRODUCTION TO COUNTS ONE THROUGH FIFTEEN

At all times material to this indictment:

1. The Medicare program was a federally funded health insurance program to provide medical care to people over the age of 65 and certain others with disabilities. The Medicare program is comprised of two parts; Part A (Hospital Insurance) and Part B (Medical Insurance). The Medicare program was administered by the Health Care Financing Administration (HCFA), an agency of the U.S. Department of Health and Human Services. In the state of Texas, HCFA contracts with Trailblazer Health Enterprises, LLC to administer the day-to-day operations of the Medicare Part B program, with the exception of the durable medical equipment program.

2. Guardian Insurance Company of America (Guardian) was a health care benefit program which provided health insurance coverage through individual contracts, and contracts with companies for their employees.

3. Texas Universities Health Plan (TUHP) was a health care benefit program which provided health insurance coverage for employees of certain universities and their affiliates. TUHP contracted with NYLCare and the University of Texas Medical Branch (UTMB) to administer their program.

4. CNA Insurance was a health care benefit plan which provided health care coverage through individual contracts, through contracts with companies and through third party administration of self-insured companies. CNA Health Partners (CNA-HP) was a subsidiary of CNA and was a third party administrator for Whataburger, CNA-HP processed and paid claims for Whataburger. CNA, as the parent company, was responsible for conducting investigations into possible fraud.

5. Medicare providers are required to apply for a provider number to enable the provider to submit claims to Medicare for services rendered to Medicare beneficiaries.

6. Health care providers are required to complete and submit a Health Insurance Claim Form (HCFA 1500) to the appropriate health care benefit program. Each HCFA claim form contains a certification that the services reflected on the claim have been provided.

7. Medicare and some private health care benefit programs allow the use of electronically submitted HCFA 1500 forms. The use of an electronically submitted HCFA Form 1500 requires a certification, signed by the provider and kept by the carrier, which states all claims submitted in this manner correctly reflect the services provided to the patient.

COUNTS ONE THROUGH SIX
(Health Care Fraud – 18 USC 1347)

B. The Scheme to Defraud Regarding Provider Number 00463M

8. Beginning on or about December 2000, and continuing to on or about April 2001, in the Southern District of Texas, and elsewhere, and within the jurisdiction of the Court, Defendant, **JOYCE LEE HICKMAN**, did devise and intend to devise a scheme and artifice to defraud the Medicare program, a health care benefit program administered by the United States Department of Health and Human Services, in connection with the payment for health care services, and for obtaining money by false pretenses or representations, and by concealing material facts.

9. The scheme to defraud the Medicare program consisted of a plan to submit false claims to the Medicare program for physician inpatient hospital visits for Medicare beneficiaries.

10. It was further part of the scheme and artifice to defraud the Medicare program that Joyce Lee Hickman would rent office space located at 9445 Country Creek, Houston, Texas 77036.

11. It was further part of the scheme and artifice to defraud the Medicare program that Joyce Lee Hickman applied for and received a Medicare provider number for a physician. The address listed on the application, and to which Medicare directed its correspondence and checks, was 9445 Country Creek, Houston, Texas 77036.

12. It was further part of the scheme and artifice to defraud the Medicare program that Joyce Lee Hickman would submit numerous claims to the Medicare program for inpatient hospital visits purportedly

provided by this physician when in truth and in fact, Joyce Lee Hickman knew such inpatient hospital visits had not been provided.

13. It was further part of the scheme and artifice to defraud the Medicare program that Joyce Lee Hickman submitted and caused to be submitted false and fraudulent claims totaling over $3,051,000 to the Medicare program from December 2000 through April 2001. The Medicare program paid over $534,000 as a result of these false claims.

C. The Execution of the Scheme to Defraud Regarding Provider Number 00463M

14. On or about the dates listed below, in the Southern District of Texas, and elsewhere, and within the jurisdiction of this Court, Defendant, **JOYCE LEE HICKMAN**, for the purpose of executing the scheme and artifice to defraud the Medicare program, in connection with the payment for health care services, and for obtaining money by means of false and fraudulent pretenses and representations, did knowingly and willfully, execute a scheme to defraud by submitting the following claims to the Medicare program for inpatient hospital visits by a physician which were never rendered on the following dates of service:

Ct.	Patient	Dates of Service	Amount Billed	False Representation
1	Dawn McCarty	5/31/00-8/21/00	$12,500	Services Not Rendered
2	Idella Conerly	2/1/00-4/30/00	$13,450	Services Not Rendered
3	Elvatous Peters	5/31/00-8/15/00	$11,650	Services Not Rendered

4	Stella Walker	3/1/00-5/20/00	$12,250	Services Not Rendered
5	Ruth Hernandez	3/31/00-6/20/00	$12,400	Services Not Rendered
6	Earl Dedmon	3/31/00-6/20/00	$12,400	Services Not Rendered

In violation of Title 18, United States Code, Section 1347.

COUNTS SEVEN THROUGH NINE
(Health Care Fraud – 18 USC 1347)

D. The Scheme to Defraud Regarding Guardian Insurance Company of America

15. Beginning on or about January 1, 2001 and continuing to on or about February 13, 2001, in the Southern District of Texas, and elsewhere, and within the jurisdiction of the Court, Defendant, **JOYCE LEE HICKMAN**, did devise and intend to devise a scheme and artifice to defraud Guardian Insurance Company of America (Guardian), a health care benefit program, in connection with the payment for health care services, and for obtaining money by false pretenses and representations, and by concealing material facts.

16. The scheme to defraud consisted of a plan by Joyce Lee Hickman to submit false claims for to [sic] Guardian for cancer treatments.

17. It was further part of the scheme and artifice to defraud Guardian that Joyce Lee Hickman owned and operated Classic Medical and Dental Clinic (Classic).

18. It was further part of the scheme and artifice to defraud Guardian that Joyce Lee Hickman claimed that two physicians worked for Classic at the time in question, when in truth and in fact, as she well knew,

the physicians did not work for Classic during that time.

19. It was further part of the scheme and artifice to defraud Guardian that Joyce Lee Hickman submitted claims for cancer treatments and surgeries purportedly performed on a patient who did not have cancer.

20. It was further part of the scheme and artifice to defraud Guardian that Joyce Lee Hickman signed false claims with one of the physician's name [sic], knowing that medical services had not been provided to the patient and such medical services had not been provided by that physician.

21. It was further part of the scheme and artifice to defraud Guardian that Joyce Lee Hickman submitted claims to Guardian for over $71,000 and received a check made payable to one of the physicians for over $7,700.

22. It was further part of the scheme and artifice to defraud Guardian that Joyce Lee Hickman deposited the above mentioned check into a bank account in the name of Classic Medical and Dental Clinic. This account is under the control of Joyce Lee Hickman.

E. <u>The Execution of the Scheme to Defraud Regarding Guardian</u>

23. On or about the dates listed below, in the Southern District of Texas, and elsewhere, and within the jurisdiction of this Court, Defendant, **JOYCE LEE HICKMAN**, for the purpose of executing the scheme and artifice to defraud Guardian Insurance Company of America, in connection with the payment for health care services, and for obtaining money by means of false and fraudulent pretenses and representations, did knowingly and willfully, execute a scheme to defraud by

submitting the following claims to Guardian for cancer treatments by a physician which were never rendered on the following dates of service:

Ct.	Patient	Dates on Claim	Amount Billed	False Representation
7	Jenazare Placek	10/31/00, 11/16/00, 11/30/00	$4,600.00	Services Not Rendered
8	Jenazare Placek	1/30/99, 2/15/99, 2/28/99, 3/15/99	$3,250.00	Services Not Rendered
9	Jenazare Placek	12/20/99	$20,146.25	Services Not Rendered

In violation of Title 18, United States Code, Section 1347.

COUNTS TEN THROUGH TWELVE
(Health Care Fraud – 18 USC 1347)

F. The Scheme to Defraud Regarding CNA/ Whataburger

24. Beginning on or about May 1, 2000 and continuing to on or about 2001, in the Southern District of Texas, and elsewhere, and within the jurisdiction of the Court, Defendant, **JOYCE LEE HICKMAN**, did devise and intend to devise a scheme and artifice to defraud a health care benefit program administered by CNA Health Partners for Whataburger (CNA/Whataburger), in connection with the payment for health care services, and for obtaining money by false pretenses and representations, and by concealing material facts.

25. The scheme to defraud consisted of a plan to submit claims to CNA/Whataburger for physical therapy treatments that were not performed.

26. It was further part of the scheme and artifice to defraud CNA/Whataburger that Joyce Lee Hickman submitted and caused to be submitted false claims for physical therapy services which were not performed.

27. It was further part of the scheme and artifice to defraud CNA/Whataburger that Joyce Lee Hickman owned and operated VIP Medical Clinic (VIP).

28. It was further part of the scheme and artifice to defraud CNA/Whataburger that Joyce Lee Hickman claimed that a certain physician worked for VIP, when in truth and in fact, as she well knew, the physician did not work for VIP.

29. It was further part of the scheme and artifice to defraud CNA/Whataburger that Joyce Lee Hickman submitted claims for physical therapy services purportedly performed on a patient who had been in an accident, when in truth and in fact, as she well knew, the patient had not been in an accident and had not received the physical therapy services.

30. It was further part of the scheme and artifice to defraud CNA/Whataburger that Joyce Lee Hickman signed false claims with the physician's name, knowing that medical services had not been provided to the patient and such medical services had not been provided by that physician.

31. It was further part of the scheme and artifice to defraud CNA/Whataburger that Joyce Lee Hickman submitted claims to CNA/Whataburger totaling over $43,000.

G. The Execution of the Scheme to Defraud Regarding CNA/Whataburger

32. On or about the dates listed below, in the Southern District of Texas, and elsewhere, and within the jurisdiction of this court, Defendant, **JOYCE LEE HICKMAN**, for the purpose of executing the scheme and artifice to defraud CNA/Whataburger, in connection with the payment for health care services, and for obtaining money by means of false and fraudulent pretenses or representations, did knowingly and willfully, execute a scheme to defraud by submitting the following claims to CNA/Whataburger for physical therapy treatments by a physician which were never rendered on the following dates of service:

Ct.	Patient	Dates of Service	Amount Billed	False Representation
10	Bridgett Roberson	9/1/99-9/30/99	$6,750.00	Services Not Rendered
11	Bridgett Roberson	10/1/99-10/31/99	$9,300.00	Services Not Rendered
12	Bridgett Roberson	11/1/99-11/11/99	$3,300.00	Services Not Rendered

In violation of Title 18, United States Code, Section 1347.

COUNTS THIRTEEN THROUGH FIFTEEN
(Health Care Fraud – 18 USC 1347)

H. The Scheme to Defraud Regarding Texas Universities Health Plans (TUHP)

33. Beginning on or about January 1, 2001 and continuing to on or about March 13, 2001, in the Southern District of Texas, and elsewhere, and within the jurisdiction of the Court, Defendant, **JOYCE LEE HICKMAN**, did devise and intend to devise a scheme

and artifice to defraud Texas Universities Health Plans (TUHP), a health care benefit program administered by NYLCare and the University of Texas Medical Branch (UTMB), in connection with the payment for health care services, and for obtaining money by false pretense and representations, and by concealing material facts.

34. The scheme to defraud consisted of a plan to submit claims to NYLCare/TUHP for cancer treatments that were not performed.

35. It was further part of the scheme and artifice to defraud NYLCare/TUHP that Joyce Lee Hickman submitted and caused to be submitted claims for cancer treatments which were not performed.

36. It was further part of the scheme and artifice to defraud NYLCare/TUHP that Joyce Lee Hickman owned and operated Classic Medical aka Classic Medical and Dental Clinic (Classic).

37. It was further part of the scheme and artifice to defraud NYLCare/TUHP that Joyce Lee Hickman claimed that a certain physician worked for Classic, when in truth and in fact, as she well knew, the physician did not work for Classic.

38. It was further part of the scheme and artifice to defraud NYLCare/TUHP that Joyce Lee Hickman submitted claims for cancer treatments purportedly performed on a patient prior to this patient being diagnosed with cancer.

39. It was further part of the scheme and artifice to defraud NYLCare/TUHP that Joyce Lee Hickman signed the false claims using the physician's name, knowing the services had not been provided to the patient and had not been provided by that physician.

40. It was further part of the scheme and artifice to defraud NYLCare/TUHP that Joyce Lee Hickman sent a facsimile to TUHP which purported to be from an employee of a United States Representative's office when in truth and in fact, as she well knew, the facsimile was not from an employee of a United States Representative's office.

41. It was further part of the scheme and artifice to defraud NYLCare/TUHP that Joyce Lee Hickman submitted claims to NYLCare/TUHP totaling over $295,000 and received over $188,600.

42. It was further part of the scheme and artifice to defraud NYLCare/TUHP that Joyce Lee Hickman deposited the above mentioned check into a bank account in the name of Classic Medical and Dental Clinic. This account is under the control of Joyce Lee Hickman.

I. The Execution of the Scheme to Defraud Regarding NYLCare/TUHP

43. On or about the dates listed below, in the Southern District of Texas, and elsewhere, and within the jurisdiction of this Court, Defendant, **JOYCE LEE HICKMAN**, for the purpose of executing the scheme and artifice to defraud NYLCare/TUHP, in connection with the payment for health care services, and for obtaining money by means of false and fraudulent pretenses and representations, did knowingly and willfully, execute a scheme to defraud by submitting the following claims to NYLCare/TUHP for cancer treatments by a physician which were never rendered on the following dates of service:

Ct.	Patient	Dates on claim	Amount Billed	False Representation
13	Dena Lee	3/2/00	$22,640.25	Services Not Rendered
14	Dena Lee	4/3/00-5/3/00	$22,919.50	Services Not Rendered
15	Dena Lee	7/3/00	$22,640.25	Services Not Rendered

In violation of 18 U.S.C. 1347.

/s/ Ralph W. Penney
Foreperson of Grand Jury

APPROVED:

MERVYN M. MOSBACKER
United States Attorney

By: /s/ Don J. Calvert
Don J. Calvert
Assistant United States Attorney

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

UNITED STATES OF AMERICA	§	
	§	
V.	§	
	§	
JOYCE LEE HICKMAN	§	**CRIMINAL NO. H-00-250**
a.k.a. JOYCE SUNDERS	§	
AND TMM MEDICAL GROUP AND TOTAL MEDICAL MANAGEMENT	§	

INDICTMENT

(Filed Apr. 8, 2004)

THE GRAND JURY CHARGES THAT:

A. INTRODUCTION TO COUNTS ONE THROUGH THREE

At all times material to this indictment:

1. The Medicare program was a federally funded health insurance program to provide medical care to people over 65 and certain others with disabilities. The Medicare program is comprised of two parts; Part A (Hospital Insurance) and Part B (Medical Insurance). The Medicare program was administered by the Health Care Financing Administration (HCFA), an agency of the U.S. Department of Health and Human Services. In the state of Texas, HCFA contracts with Trailblazer Health Enterprises, LLC (formerly Texas Blue Cross and Blue Shield) to administer the day-to-day operations of the Medicare Part B program, with the exception of the durable medical equipment (DME) program. DME operations are administered by

DME regional centers (CMERCs). The DMERC responsible for Texas is Palmetto Government Benefits Administrators (Palmetto GBA).

2. The Texas Medicaid program was a cooperative federal-state program to provide medical assistance to the indigent. The Texas Medicaid program is administered by the Texas Health and Human Services Commission (THHSC). THHSC contracts with the National Heritage Insurance Company (NHIC) to process claims submitted by health care providers.

3. Total Medical Management was a durable medical equipment (DME) provider under the Medicare and Medicaid programs.

4. Total Medical Management also operated as a billing company which submitted claims to Medicare, Medicaid and other medical insurance companies on behalf of physicians who retained Total Medical Management as their billing service.

5. TMM Medical Group was purportedly a medical clinic located at 8120 Corinth, Houston, Texas. In fact, from December 1996 until January 1999, TMM Medical Group had only office space, had no physicians in its employ and neither examined or treated patients.

   TMM Medical Group applied for and received group provider numbers from the Medicare and Medicaid programs as a medical clinic. TMM Medical Group also applied for and received provider numbers for two physicians purportedly in their employ.

6. Joyce Lee Hickman was the true owner and operator of both Total Medical Management and TMM Medical Group. Her father, Joe Payton Lee, is listed as the owner and president of TMM Medical Group on the Medicare and Medicaid applications for provider numbers.

7. Medicare and Medicaid providers were required to complete and submit a Health Insurance Claim form ("HCFA Form 1500"). Each HCFA Form 1500 contained a certification, signed by the provider, which stated that the services reflected on the form had been provided.

8. Medicare and Medicaid also permit the use of an electronically submitted HCFA Form 1500. The use of an electronically submitted HCFA Form 1500 requires a certification, signed by the provider and kept by the carrier, which states that all claims submitted in this manner correctly reflect the services provided to the Medicare and Medicaid beneficiaries. Such a certification was on file for Joyce Lee Hickman and her companies.

9. Medicare and Medicaid requires certificates of medical necessity (CMN's) for certain DME items such as seat lift chairs, mattresses, etc. These CMN's must be completed and signed by a physician. The provider maintains these CMN's to support their claim and makes them available to Medicare upon request.

COUNTS ONE THROUGH THREE
(Health Care Fraud – 18 USC 1347)

B. The Scheme to Defraud Regarding DME

10. Beginning on or about March 7, 1995, and continuing to on or about February 1997, in the Southern District of Texas, and elsewhere, and within the jurisdiction of the Court, Defendants,

JOYCE LEE HICKMAN
a.k.a. JOYCE SAUNDERS and
TOTAL MEDICAL MANAGEMENT

did devise and intend to devise a scheme and artifice to defraud the Medicare program, a health care program administered by the United States Department of Health and Human Services, in connection with the payment for health care services, and for obtaining money by means of false and fraudulent pretenses, representations, and by concealing material facts.

11. It was further part of the scheme and artifice to defraud the Medicare program to submit claims to the Medicare program for durable medical equipment (DME) provided to Medicare beneficiaries who did not need, and whose physicians did not prescribe, the DME. In addition, some claims were submitted for DME which was never provided to the beneficiary.

12. It was further part of the scheme and artifice to defraud the Medicare program that Joyce Lee Hickman to applied and received for a Medicare supplier number from Palmetto GBA.

13. It was further part of the scheme and artifice to defraud the Medicare program for Joyce Lee Hickman and other unknown employees of Total Medical Management to approach beneficiaries and offer to supply them with DME at no cost to the beneficiary. Information needed to submit claims to the Medicare program, such as names, addresses, dates of birth, Medicare numbers, etc., was obtained from the beneficiary and soon thereafter some of the beneficiaries would receive the DME.

14. It was further part of the scheme and artifice to defraud the Medicare program that Joyce Lee Hickman and other employees of Total Medical Management would cause to be submitted and would submit claims to Medicare for this DME listing one of three doctors as the

referring physician when in fact and in truth, Joyce Lee Hickman knew that none of these physicians had authorized or prescribed these DME items billed.

15. It was further part of the scheme and artifice to defraud the Medicare program that Joyce Lee Hickman would produce forged CMN's to the Medicare program when asked for documentation on the claims that Medicare chose for review.

16. It was further part of the scheme and artifice to defraud the Medicare program that Joyce Lee Hickman caused claims in excess of $1 million to be submitted to Medicare. As a result, Medicare paid Total Medical Management over $300,000.

C. The Execution of the Scheme to Defraud Regarding DME

16. From on or about March 7, 1995 through February 1997, in the Southern District of Texas, and elsewhere, and within the jurisdiction of this Court, Defendants,

JOYCE LEE HICKMAN
a.k.a JOYCE SAUNDERS and
TOTAL MEDICAL MANAGEMENT

for the purpose of executing the scheme and artifice to defraud the Medicare program, a health care benefit program administered by the United States Department of Health and Human Services, in connection with the payment for health care services, and for obtaining money by means of false and fraudulent pretenses or representations, did knowingly and willfully, execute a scheme to defraud by submitting claims to the Medicare program for DME items which were not authorized or prescribed by a

physician as required by the Medicare program, by listing a referring physician on the claim when neither that physician, nor any other physician, had authorized or prescribed such DME, for the following dates of service:

Ct.	Beneficiary	Claim Number	Date	Amt. Pd.	False Statement
1	Lee Perkins	9527781 1094000	9/21/95	$3,820.54	Items Not supplied
2	Joyce Richardson	9611681 8952000	4/22/96	$1289.80	Items Not supplied
3	Agatha Moore	9611681 8951000	4/22/96	$1289.80	Items Not supplied

In violation of 18 United States Code, Section 1347.

COUNTS FOUR THROUGH SEVENTEEN
(Health Care Fraud – 18 USC 1347)

D. The Scheme to Defraud Regarding Hospital Visits

17. Beginning on or about December 22, 1996, and continuing to on or about May 1999, in the Southern District of Texas, and elsewhere, and within the jurisdiction of this Court, Defendants,

JOYCE LEE HICKMAN
a.k.a. JOYCE SAUNDERS and
TOTAL MEDICAL MANAGEMENT and
TMM MEDICAL GROUP

did devise and intend to devise a scheme and artifice to defraud the Medicare and Medicaid programs, health care benefit programs administered by the United States Department of Health and Human Services, in connection with the payment for health services, and for obtaining

money by means of false and fraudulent pretenses, representations and by concealing material facts.

18. The scheme to defraud consisted essentially of a plan to submit claims to the Medicare program for physician inpatient hospital visits to Medicare and Medicaid beneficiaries that were not performed.

19. It was further part of the scheme and artifice to defraud the Medicare and Medicaid programs that Joyce Lee Hickman would operate Total Medical Management as a billing company. In this manner she had access to numerous Medicare and Medicaid beneficiaries' names and identifying information which she used to create false and fraudulent Medicare and Medicaid claims.

20. It was further part of the scheme and artifice to defraud the Medicare and Medicaid programs that Joyce Lee Hickman applied for and received Medicare and Medicaid provider numbers of TMM Medical Group, and for two physicians purportedly working for TMM Medical Group.

21. It was further part of the scheme and artifice to defraud the Medicare and Medicaid programs that Joyce Lee Hickman represented that these two physicians worked for TMM Medical Group, when in truth and in fact, Joyce Lee Hickman knew neither of these two physicians was employed by or worked for TMM Medical Group.

22. It was further part of the scheme and artifice to defraud the Medicare and Medicaid programs that Joyce Lee Hickman submitted and caused to be submitted claims to the Medicare and Medicaid programs for inpatient hospital visits purportedly provided by these two

physicians when in truth and in fact, Joyce Lee Hickman knew such inpatient hospital visits had not been provided.

23. It was further part of the scheme and artifice to defraud the Medicare and Medicaid programs that Joyce Lee Hickman submitted and caused to be submitted numerous claims for services purportedly provided on the same day when the time needed to perform those services exceeds twenty-four hours [per day]. A review was conducted of claims submitted for fifty-two dates of service [per day]. Under one physician's provider number, there were at least four dates which had claims for over twenty-four hours of services. The other physician's provider number had at least ten dates on which the amount of time included on all the claims exceeded twenty-four hours [per day].

24. It was further part of the scheme and artifice to defraud the Medicare and Medicaid programs that Joyce Lee Hickman submitted and caused to be submitted claims for beneficiaries who were deceased. A review of 85 randomly chosen beneficiaries revealed that Hickman submitted claims for alleged services provided to a deceased beneficiaries at least five times.

25. It was further part of the scheme and artifice to defraud the Medicare and Medicaid programs that Joyce Lee Hickman submitted and caused to be submitted false and fraudulent claims for over $12 million to the Medicare and Medicaid programs from 1997 to 1999. The Medicare and Medicaid programs paid TMM Medical Group over $5 million as a result of these claims.

E. The Execution of the Scheme to Defraud Regarding Hospital Visits

26. On or about the dates listed below, in the Southern District of Texas, and elsewhere, and within the jurisdiction of this Court, Defendants,

JOYCE LEE HICKMAN
a.k.a. JOYCE SAUNDERS and
TOTAL MEDICAL MANAGEMENT and
TMM MEDICAL GROUP

for the purpose of executing the scheme and artifice to defraud the Medicare and Medicaid programs, (health care benefit programs administered by the United States Department of Health and Human Services), in connection with the payment for health care services, and for obtaining money by means of false and fraudulent pretenses, representations, did knowingly and willfully, execute a scheme to defraud by submitting the following claims for services to the Medicare and Medicaid programs for inpatient hospital visits by physicians which were never rendered on the following dates of service:

Ct.	Patient	Claim Number	Dates of Service	Amt. Pd.	False Representation
4	Frankie Carson	2298056846560	12/31/96-3/28/97	$4,449.79	Services Not Rendered
5	Rayford Pryor	2297339670280	1/3/97-3/30/97	$4,723.40	Services Not Rendered
6	Agatha Moore	2898194001580	1/31/97-4/2/97	$2,976.49	Services Not Rendered
7	Ashley Steptoe	201397324013657	9/15/97-9/27/97	$731.72	Services Not Rendered
8	Ebony Jackson	201397324007519	9/30/97-10/13/97	$784.12	Services Not Rendered
9	Susie Allen	2298093692310 3010981070164 76	10/2/97-12/31/97	$6,172.80	Services Not Rendered
10	Passion McGuire	201397324013658	10/11/97-10/23/97	$731.72	Services Not Rendered
11	Marguerit Durall	2298092383660 3010981060020 85	10/15/97-12/31/97	$5,299.98	Services Not Rendered
12	Chevalier Paige	201398029008003	12/1/97-12/12/97	$679.32	Services Not Rendered
13	Mille Mae Jones	2298308269290 3018983220060 23	5/31/98-8/2/98	$4,655.65	Services Not Rendered
14	Lee Perkins	2298285234680	6/29/98-8/31/98	$3,781.53	Services Not Rendered
15	Pearl Addison	201398310001018	9/11/98-9/23/98	$710.23	Services Not Rendered
16	Mildred Smith	2299074413460 3018990880290 28	10/31/98-1/10/99	$4,062.36	Services Not Rendered
17	Gracie Ramirez	2299084740510	1/2/99-3/3/99	$2,686.35 *	Services Not Rendered

* In violation of 18 United States Code, Section 1347.

COUNTS EIGHTEEN THROUGH TWENTY-ONE
(Money Laundering – 18 USC 1957)

27. On or about the dates below, in the southern District of Texas, and elsewhere, and within the jurisdiction of this court, Defendants,

JOYCE LEE HICKMAN
a.k.a. JOYCE SAUNDERS and
TOTAL MEDICAL MANAGEMENT and
TMM MEDICAL GROUP

knowingly engaged or attempted to conduct the following described financial transactions affecting interstate commerce, to wit: the following described withdrawals of funds from Sterling Bank, account number 21021478, which involved the proceeds of a specified unlawful activity, that is, health care fraud, in violation of Title 18, United States Code Section 1347, as charged in counts one through twenty-four of this indictment, knowing that the transactions involved proceeds from a criminal offense that was of a value greater than $10,000, and that while conducting and attempting to conduct such financial transactions knew that the property involved in the financial transactions, that is funds in the stated amounts, represented the proceeds of some form of specified unlawful activity.

Count	Payee	Check No.	Date	Amount
18	Neiman Marcus	4504	2/22/99	$53,583.75
19	Sterling Bank Post Oak Motors	Acct. Debit 568344	3/30/99 3/30/99	$51,253.92 $51,253.92
20	Louis Vuitton	5041	12/17/98	$30,147.63
21	Sterling Bank American Title Co.	Teller Check 566425	8/3/98 8/3/98	$80,000.00 $80,000.00

In violation of 18 United States Code, Section 1957.

COUNT TWENTY TWO
(SSN Misuse – 42 USC 408(a)(7)(B))

28. On or about February 14, 1997 in the southern District of Texas, **JOYCE LEE HICKMAN**, Defendant herein, for the purposes of concealing her identity from a financial institution, did willfully, knowingly, and with the intent to deceive, falsely represent Social Security Account Number 449-13-2500 to be the Social Security Account Number assigned to her by the Commissioner of the Social Security Administration, when in fact as the Defendant well knew, such number had not been assigned to her by said Commissioner of the Social Security Administration.

In violation of Title 42. United States Code, Section 408(a)(7)(B).

COUNT TWENTY THREE
(Criminal Forfeiture – 18 U.S.C. § 982)

1. The Grand Jury further alleges that, pursuant to Title 18, United States Code, Section 982, as a result of the offenses stated above,

JOYCE LEE HICKMAN
a.k.a. JOYCE SAUNDERS and
TOTAL MEDICAL MANAGEMENT and
TMM MEDICAL GROUP

shall forfeit to the United States of America all property which constitutes or is derived, directly or indirectly, from gross proceeds traceable to a violation of 18 U.S.C. § 1347; as well as any and all interest in property, real or personal, involved in a violation of 18 U.S.C. §1957, and any property traceable to such property, including but not limited to:

(a) Approximately Forty nine thousand dollars in United States currency, and all interests and proceeds traceable thereto;

(b) 1912 CALUMET, HOUSTON, TEXAS (a tract of land 55 feet by 150 feet out of the Guiseppe Miceli 2.37 acre tract in the Joseph Christy Survey, Abstract No. 212, Harris County, Texas), and all rents or other income therefrom;

(c) A 1989 Rolls Royce Silver Spur. VIN SCAZN02A8KCX26535;

(d) One Lady's 18 Kt Yellow Gold Necklace set with 192 Round Brilliant Cut Diamonds weighing approximately 16.43 Carats – Original design by Jose Hess;

(e) One Louis Vuitton Stokowski Desk Trunk Model M11040;

2. In the event that the above-described property, as a result of any act or omission of

JOYCE LEE HICKMAN
a.k.a. JOYCE SAUNDERS and
TOTAL MEDICAL MANAGEMENT and
TMM MEDICAL GROUP

cannot be located upon the exercise of due diligence, has been transferred or sold to or deposited with a third party, has been placed beyond the jurisdiction of the Court, has been substantially diminished in value, or has been commingled with other property which cannot be divided without difficulty, it is the intent of the United States of America to seek the forfeiture of any other property of

JOYCE LEE HICKMAN
a.k.a. JOYCE SAUNDERS and
TOTAL MEDICAL MANAGEMENT and
TMM MEDICAL GROUP

up to the value of the above-described property, pursuant to Title 21, United States Code, Section 853(p), made applicable to these offenses by Title 18, United States Code, Section 982(b)(1)(A).

All in violation of Title 18. United States Code, Section 982.

A TRUE BILL

/s/ Greg Raswell
FOREPERSON

/s/ Don J. Calvert
DON CALVERT
Assistant United States
Attorney

129 Fed.Appx. 61

This case was not selected for publication in the Federal Reporter. Please use FIND to look at the applicable circuit court rule before citing this opinion. Fifth Circuit Rule 47.5.4.

United States Court of Appeals, Fifth Circuit.
UNITED STATES of America,
Plaintiff-Appellee,
v.
Joseph R. KIRKHAM; James Mark Murphy,
Defendants-Appellants.

No. 03-11030.

Decided April 11, 2005.

William C. Brown, Washington, DC, for Plaintiff-Appellee.

Ronald Gordon Couch, Law Offices of Ronald G. Couch, Hurst, TX, for Defendants-Appellants.

Appeal from the United States District Court for the Northern District of Texas (4.02-CR-011-Y(03)).

Before REAVLEY, WIENER, and BENAVIDES, Circuit Judges.

WIENER, Circuit Judge:*

Defendant-appellants James Murphy, M.D., and Joseph Kirkham (collectively, "defendants") appeal their respective criminal convictions for health care fraud under 18 U.S.C. §§ 1347 and 2. They raised numerous challenges

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* Pursuant to 5th Cir. R. 47.5, the court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5th Cir. R. 47.5.4.

to their convictions and sentences, several of which are grounded on their argument that the government improperly indicted them by including only one count in its indictment while listing several other discrete executions of defendants' alleged scheme to commit health care fraud as examples rather than as separate counts. Although we conclude that the government's indictment was flawed – specifically, duplicitous – we hold that, because defendants experienced no prejudice as a result of the duplicitous indictment or of any trial errors that they asserted, their convictions should be affirmed. As for their sentences, however, the Supreme Court's recent decision in *United States v. Booker*[2] requires us to hold that defendants' Sixth Amendment rights were violated by the district court's calculation of loss and concomitant sentencing under the then-binding United States Sentencing Guidelines. We therefore vacate defendants' sentences and remand for resentencing.

I. FACTS AND PROCEEDINGS

In May 2003, a jury convicted Kirkham and Murphy of health care fraud, in violation of 18 U.S.C. §§ 1347[3] and 2.[4] The three-page indictment charged each defendant

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[2] ___ U.S. ___, 125 S.Ct. 738, 160 L.Ed.2d 621 (2005).

[3] Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice –

> (1) to defraud any health care benefit program . . . in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both . . .

[4] (a) Whoever commits an offense against the United States or aids, abets, counsels, commands, induces or procures its commission, is punishable as a principal.

(Continued on following page)

with only one count, alleging that they had executed and attempted to execute a scheme to defraud various health care benefit plans from August 1996 through the year 2000. In October 2003, the district court sentenced Kirkham to 120 months of imprisonment and ordered him to pay restitution of $2,751,270. Murphy was sentenced to 87 months of imprisonment and ordered to pay restitution of $732,061.

A. The Indictment

The government indicted Kirkham, Murphy, and Alvin Lostetter, M.D., on one count of executing or attempting to execute a scheme to commit fraud on health care benefit programs.[5] Part A of the indictment states the duration of the scheme, August 1996-2000, its location, the defendants' names, and the identities of several health care benefit providers that defendants were charged with defrauding. It goes on to describe the scheme as an effort to "obtain by means of false and fraudulent pretenses, representations, and promises, money owned by and under the custody and control of health care benefit programs in connection with the delivery of and payment for health care benefits, items, and services."

Part B of the indictment describes defendants' scheme in greater detail. It lists seven components of the scheme, including creating phony medical business entities and

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(b) Whoever willfully causes an act to be done which if directly performed by him or another would be an offense against the United States, is punishable as a principal.

[5] Although he was indicted with Kirkham and Murphy, Lostetter did not go to trial with them.

names, billing under the names of doctors who did not provide or supervise medical services, recruiting patients with false representations, providing false medical diagnoses, and using chiropractors and unlicensed personnel to recruit "patients" and render medical diagnoses and treatment consistent with the scheme and the amount of health insurance carried by the patient, rather than according to the true medical needs of the patient. Part B also states that the health care benefit programs provided payments to defendants based on the submission of false claims and diagnoses, and that defendants received and shared these proceeds pursuant to their scheme.

Part C of the indictment lists 13 particular transactions executed or attempted to be executed in perpetrating the scheme to defraud. Each transaction listed included the date of the billing, the name of the medical insurance provider, the doctor's name under which services were billed, and the name(s) of the patient(s). Four of these transactions named Lostetter as the physician providing services, one transaction named Kirkham and Lostetter as physician providers, and eight transactions named Murphy. All 13 listed transactions took place after August 1996. The indictment does not specify which of the individually listed transactions would be used at trial to illustrate defendants' execution of the scheme.

B. Health Care Clinic and Gym Scheme

The government asserted at trial that, beginning in 1993, Kirkham, along with several other individuals, conducted a continuing scheme to defraud health care benefit programs through their operation of health care clinics associated with gyms and health clubs; Murphy

joined Kirkham in operating the scheme in 1997. Kirkham and Mark Darner, a chiropractor, operated the scheme along with Murphy and other medical doctors, including Lostetter and Victor McCall. Darner pleaded guilty to conspiracy to commit mail fraud and testified about the health care fraud scheme at Kirkham and Murphy's trial.

Darner testified that he and Kirkham set up health care clinics inside a number of health clubs of which they were majority owners, and that they used the club sites to solicit and direct new patients to the clinics. Murphy's, Lostetter's, and McCall's names were often used in billing insurers, said Darner, explaining that insurers are more likely to reimburse and to pay a higher rate for invoices submitted by doctors than those from chiropractors. According to Darner, Kirkham was the CEO and principal operator of the health clubs. He directed Darner regarding implementation of the scheme.

Defendants implemented a standing procedure that required each new fitness club member to be examined in the clinic. While Murphy was associated with the clinics in 1997 and 1998, they employed a written treatment protocol authored by Kirkham, Murphy, and Darner. This protocol specified listed treatments to be given to each new "patient" or gym member at the five or six clinics being operated at the time, with explicit instructions not to modify treatment unless it was contraindicated. Clients were assigned treatment classifications based on their insurance coverage. For the first visit of a member/client who had insurance, the protocol required a new patient exam, range of motion analysis, scanning EMG, thermography, and radiographs regardless whether tests and these treatments were indicated as required by the patient. The second automatic visit protocol called for more

extensive tests and treatment, including billing for a number of other diagnostic tests.

Testifying at Kirkham and Murphy's trial were (1) Darner, (2) Victor McCall, another physician who participated in the scheme, and (3) Charles Stafford, a staff chiropractor, as well as several clinic "patients," a medical transcriber, and an expert witness. The witnesses who had participated in the scheme with defendants described the nature of the scheme in detail, including the process used for submitting the fraudulent claims. The clinic's clients testified that, after joining the health club for fitness reasons, they were told to go to the clinic for unwanted and unnecessary medical exams. Several clients identified false listings of symptoms and diagnoses in their files and confirmed that claims sent to their insurance companies were false.

The government also presented an expert witness, Charles Crane, M.D., who testified that defendants' billing and testing procedures were inappropriate and fraudulent. Eeletha Williams, a medical transcriber who worked for Murphy from 1995 to 1999 testified that most of Murphy's patient reports contained a note stating that the billing had been dictated but not read by Murphy, even though Murphy had not dictated, reviewed, or provided any information for the reports. She also stated that Murphy told her on several occasions that the reports were too short and asked her to generate more lengthy patient reports containing false information.

C. Oxylab

Oxylab was another company of which Murphy was medical director. Karen Musch, an employee of Oxylab,

pleaded guilty to mail fraud and testified against Murphy. Musch testified that she served as medical director of a fraudulent sleep apnea study conducted by Oxy-Lab, and that Murphy participated in the study during the time that he was active in the health club scheme with Kirkham. Musch stated that Murphy never performed or read any sleep apnea tests, yet he submitted insurance claims purporting to bill providers for his services related to the study. Several insurance billings listed in Part C of the indictment were claims processed and paid by health care benefit programs for this sleep apnea study.

II. ANALYSIS

A. Sufficiency of the Evidence

1. *Standard of Review*

We review challenges to sufficiency of the evidence by examining whether, in the light most favorable to the government, a rational jury could have found the essential elements of an offense to be established beyond a reasonable doubt.[6]

2. *The Evidence*

Defendants' challenge to the sufficiency of the evidence rests, in large part, on their assertion that the government's one-count indictment against them was flawed. They contend that, according to our decision in *United States v. Hickman*, when charging defendants with violations of the health care fraud statute, 18 U.S.C. § 1347 ("§ 1347"), the government is *required* to charge

[6] *United States v. Solis*, 299 F.3d 420, 445 (5th Cir.2002).

each execution of their fraudulent scheme in a *separate* count.[7] In this case, the government included a list of "executions" in the one-count indictment but did not single out any specific acts on which the jury must have agreed to convict. Defendants contend that this is contrary to *Hickman* and, because of this defect in the indictment, the evidence was insufficient to support their convictions. They insist that the government was required to (1) list each execution of the scheme separately and (2) prove the commission of each execution listed in the indictment.

In addition to their *Hickman* argument, defendants assert that their indictment was duplicitous, i.e., that it charged in a single count that which could have been charged in separate counts.[8] Finally, defendants argue that, because several of the transactions enumerated in Part C list Victor Lostetter as the physician who provided the treatment, and the government did not produce evidence to prove that these transactions were fraudulent, the government did not meet its burden of proof with respect to these transactions. We address defendants' challenge to their indictment in some detail, as it reappears several times, underlying many of the other challenges to their convictions and to their sentences.[9]

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[7] *See* 331 F.3d 439, 446 (5th Cir.2003), on remand at 282 F.Supp.2d 528 (S.D.Tex.2003), affirmed by 374 F.3d 275 (5th Cir.2004), vacated and remanded for re-sentencing in accordance with *United States v. Booker*, ___ U.S. ___, 125 S.Ct. 738, 160 L.Ed.2d 621 (2005), ___ U.S. ___, 125 S.Ct. 1043, 160 L.Ed.2d 1041 (2005).

[8] *See United States v. Baytank*, 934 F.2d 599, 609 (5th Cir.1991).

[9] The defendants do not directly challenge the indictment itself on appeal but argue only that, because the indictment was duplicitous, this error contributed to other trial errors.

First, defendants are mistaken in their assertion that *Hickman* requires the government to charge health care fraud defendants for each separate execution of their scheme to defraud health care benefit providers. In *Hickman*, we held that the health care fraud statute, like the bank fraud statute,[10] criminalized *executions* of schemes to defraud, in contrast to the mail and wire fraud statutes, which permit the government to charge a defendant for each *act in furtherance* of a scheme to defraud.[11] We did *not* hold that the government *must* charge defendants with each separate execution of § 1347, stating instead that, as a health care fraud may be executed several times, the government *could* charge each execution in a separate count.[12] In essence, we sought to clarify that the government may not indict defendants for violations of § 1347 without charging that they *fully executed* a scheme, as distinguished from only committing overt acts *in furtherance of* its execution.

Other circuits have encountered similar challenges to single-count indictments brought under the bank fraud statute and have agreed that, although the government may charge defendants for each execution of the scheme, it

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[10] 18 U.S.C. § 1344.

[11] 331 F.3d at 446 (citing *United States v. Lemons*, 941 F.2d 309 (5th Cir.1991) for this interpretation of the bank fraud statute).

[12] 331 F.3d at 446 ("Of course, although the crime of health care fraud is complete upon the execution of a scheme, any scheme can be executed a number of times, and each execution *may* be charged as a separate count.") (emphasis added).

is not required to do so.[13] The Seventh Circuit's reasoning, endorsed by the Ninth and D.C. Circuits, explained that:

> [F]or each count of conviction, there must be an execution. However, the law does not require the converse: each execution need not give rise to a charge in the indictment. The indictment in this case sets forth the existence of the scheme and alleges the scheme was executed on at least one occasion. The allegations tending to demonstrate the existence of the scheme do appear to be allegations that, if worded and structured differently, might constitute additional executions. This is hardly surprising; the actions that tend to prove the existence of the scheme will often be the actions actually taken to execute the scheme.[14]

Each court also emphasized, however, that to avoid duplicity, the government must carefully craft its indictment to include only one execution of a scheme in a count.[15]

As the government was not required to charge Kirkham and Murphy with each execution of the scheme, but instead could indict them for the scheme by charging only one execution, we must determine whether the government

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[13] *United States v. King*, 200 F.3d 1207, 1212-13 (9th Cir.1999) (rejecting a defendant's due process and double jeopardy challenges to a one-count indictment); *United States v. Bruce*, 89 F.3d 886, 889-90 (D.C.Cir.1996) (holding that the government need not indict a defendant on every execution of a bank fraud scheme); *United States v. Hammen*, 977 F.2d 379, 383-84 (7th Cir.1992) (upholding a one-count indictment despite allegations in the indictment that could, if worded and structured differently, be chargeable as individual counts).

[14] *Hammen*, 977 F.2d at 383; *see also King*, 200 F.3d at 1213; *Bruce*, 89 F.3d at 889-90.

[15] *See King*, 200 F.3d at 1213; *Bruce*, 89 F.3d at 890; *Hammen*, 977 F.2d at 384.

carefully crafted its indictment to charge only one execution, and thereby avoid a duplicitous indictment. We begin by defining "executions" of a scheme to determine whether more than one is charged in a single-count.

In *Hickman*, we described an "execution" under § 1347 in the same manner as an execution of § 1344, the bank fraud statute, viz., that transactions with a common purpose but involving separate and independent obligations to be truthful may constitute separate executions.[16] The process of defining "execution of a scheme" is a fact-intensive one in which we consider such factors as (1) the ultimate goal of the scheme, (2) the nature of the scheme, (3) the benefits intended, (4) the interdependence of the acts, and (5) the number of parties involved.[17]

In *Hickman*, the defendant was accused of billing Medicare, Medicaid, and a variety of private insurance companies in a series of fraudulent transactions.[18] Applying the foregoing factors and other prior interpretations of § 1344 (the bank fraud statute) to § 1347, we held the fourth factor, interdependence, to be dispositive.[19] The defendant submitted each claim separately and, with each

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[16] *Id.*, citing *United States v. De La Mata*, 266 F.3d 1275, 1287 (11th Cir.2001).

[17] *Id.*, citing *De La Mata*, 266 F.3d at 1288 (citations omitted).

[18] *Id.* at 441.

[19] *Id.* We concluded that the other four factors were unhelpful: The nature of the scheme was to submit false claims to health insurers; the benefit was the money rendered by the insurer to the defendant; financial gain was the ultimate goal; and the defendant defrauded several parties, although she primarily targeted Medicare and Medicaid. *Id.* at 446-47. These factors are identical in the instant case, except that Kirkham and Murphy targeted a wider variety of health care benefit providers than had Hickman.

submission, owed a new and independent obligation to be truthful to the insurer.[20] Therefore, each claim submission was a separate execution of the scheme.[21]

The government indicted Kirkham and Murphy for virtually the same conduct-submitting false claims to a variety of health insurers – as that for which it had prosecuted the *Hickman* defendant. As in *Hickman,* these defendants submitted numerous false claims to a variety of health insurers which were not interdependent, with financial gain as defendants' ultimate goal. We conclude that, as in *Hickman,* each false claim submitted to an insurer constituted an execution of Kirkham and Murphy's scheme.[22] The indictment itself appears so to define the listed claims, as it states that "[i]n execution and attempting to execute the scheme . . . medical claims were submitted and caused to be submitted by the defendants . . . " before listing in Part C the separate claims submitted by defendants. We are satisfied that Part C of the indictment did charge defendants in one count with several executions of their scheme when it listed 13 false claims submitted without specifying which of these claims would be used at trial to demonstrate that defendants executed their scheme.

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[20] *Id.*

[21] *Id.*

[22] Ordinarily, the process of defining a scheme under the health care fraud, or the bank fraud, statute, would be more laborious. In this case, the facts are so similar to the facts set forth in *Hickman* that we see no need to re-hash an explanation of why the defendants' conduct constituted executions of the scheme in greater detail. *See* 331 F.3d at 446-47.

Section 1347 does not criminalize the scheme alone – the government must prove at least one execution of the scheme, and the indictment should specify which execution of the scheme will be used.[23] The indictment brought against Kirkham and Murphy lists 13 allegedly fraudulent claims without singling out one particular claim as the one for which liability will be imposed.[24] Had the indictment listed several transactions as examples of executions of the schemes but had also been "carefully crafted" to identify one specific transaction that constituted execution of the scheme and on which the jury must agree before convicting defendants, the indictment would not have been duplicitous; however, it did not do so.[25]

Despite this flaw in the indictment, though, the government adduced trial evidence sufficient to sustain defendants' convictions. With respect to Murphy, in addition to evidence of the broader fraudulent scheme, two of the patients listed in Part C as "treated" by Murphy, Joyner and Hancock, testified at trial as did Stafford, the chiropractor involved with their treatment. All three confirmed that Murphy's billings for services ostensibly provided by him to these patients were fraudulent. As for the six patients listed in Part C as receiving sleep apnea

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[23] *See Hammen*, 977 F.2d at 383.

[24] *See Bruce*, 89 F.3d at 890 (holding valid a one-count bank fraud indictment listing acts taken in furtherance of the scheme but that could have been charged separately as executions, because the indictment specified *one* fraudulent transaction taken "for the purpose of executing . . .").

[25] *See id.*; *Hammen*, 977 F.2d at 383 (upholding one-count indictment and noting that "the government has carefully crafted the indictment to allege only one execution of an ongoing scheme that was executed numerous times.").

services billed by Murphy as part of the OxyLab study, the government also produced ample evidence of fraud. The patients' testing and Medicare claim records were introduced into evidence, and the director of OxyLab testing, Karen Musch, testified as to Murphy's negligible involvement in the study and in services for which fraudulent claims were submitted to insurers. The government produced sufficient evidence to support the jury's verdict on every one of the executions listed in Part C of the indictment as being submitted by Murphy.

Substantial evidence also supported Kirkham's conviction for his role in this health care clinic scheme. Darner testified that he and Kirkham originally set up the scheme and handled all billing themselves. Darner also testified that he, Kirkham, and Murphy conspired to commit health care fraud by fraudulently billing insurance companies, and that Kirkham was the "main boss" of the operation. And, McCall, a medical doctor, testified that he participated in the scam with Kirkham and Darner after Murphy had left the clinic. Even though the government included only one execution of the scheme in which Kirkham was listed as the medical provider and did not produce the named patient as a witness at trial, the overwhelming evidence of Kirkham's involvement with the scheme and significant participation in the billing procedures support a finding that he worked with Murphy to execute the scheme on the other listed occasions.

The government need not prove all facts alleged in the indictment as long as it proves the essential elements of the crime.[26] In this case, the government was required to

[26] *United States v. Robinson*, 974 F.2d 575, 578 (5th Cir.1992).

show that the defendants: (1) knowingly and willfully (2) executed or attempted to execute (3) a scheme or artifice (4) to defraud any health care benefit program (5) in connection with the delivery of or payment for health care benefits, items, or services[27]; or that they (a) aided, abetted, counseled, commanded, induced or procured such an offense or (b) willfully caused an act to be done which, if it had been directly performed by the defendant, would have constituted such an offense.[28] Even if we assume that the government did not adduce adequate evidence to support conviction for the claims listing Lostetter as the physician provider, it presented ample evidence to prove each element of the offense with respect to each defendant.[29] For this reason we also reject defendants' argument that the government failed to meet its burden of proof with respect to fraudulent transactions listed in the indictment that identified Lostetter as the treating physician.[30]

In sum, even though the indictment was flawed, making it somewhat more difficult to ascertain for which of the executions the jury convicted defendants, the

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[27] 18 U.S.C. § 1347(1).

[28] 18 U.S.C. § 2.

[29] *See Griffin v. United States*, 502 U.S. 46, 49, 58-59, 112 S.Ct. 466, 116 L.Ed.2d 371 (1991) (holding that, although petitioner was convicted of conspiracy despite the government's failure to present any evidence linking the petitioner to *one* of the two illegal objects of the conspiracy as stated in the indictment, this did not require reversal of the jury's verdict as there was evidentiary support for the other object. Although reversal is appropriate where a jury's verdict may have rested on a *legally* inadequate basis, such is not the case when one possible basis of conviction was unsupported by sufficient evidence, as juries are perfectly well equipped to evaluate the evidence).

[30] As we noted above, Lostetter was indicted with the defendants but was not tried with them.

government produced sufficient evidence to support the jury's finding that Murphy and Kirkham were each responsible for at least one listed execution of the scheme. We hold that the indictment's flaw did not affect defendants' substantial rights and that the evidence was sufficient to support the jury's verdict beyond a reasonable doubt.

B. "Void for Vagueness" Statutory Challenge

1. *Standard of Review*

We review challenges to the constitutionality of a statute *de novo*.[31]

2. *Vagueness*

Defendants charge that, under the circumstances of this case, § 1347 is "void for vagueness." Their argument rests largely on claimed deficiencies in the jury instructions and in the indictment, which we discuss elsewhere in this opinion. Otherwise, defendants contend that, because the statute does not define "execution or attempt to execute" a health care fraud scheme, it did not adequately put them on notice that their conduct could be illegal.

The Supreme Court requires that Congress define criminal offenses with "sufficient definiteness that ordinary people can understand what conduct is prohibited and in a manner that does not encourage arbitrary and discriminatory enforcement."[32] Each vagueness challenge

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[31] *United States v. Monroe*, 178 F.3d 304, 308 (5th Cir.1999).

[32] *Kolender v. Lawson*, 461 U.S. 352, 357, 103 S.Ct. 1855, 75 L.Ed.2d 903 (1983).

that does not involve First Amendment freedoms must be examined in light of its individual facts and circumstances.[33] A challenge that a statute is unconstitutional for vagueness is closely related to an objection that a statute does not require a showing of specific intent.[34] If a statute does include "willfulness" or specific intent as an element, it will normally not be so vague as to deprive a defendant of reasonable notice that his conduct is proscribed.[35] Accordingly, we have upheld the constitutionality, against vagueness challenges, of both the bankruptcy fraud statute and former 18 U.S.C. § 1346, the general anti-fraud statute, because each requires the government to prove specific intent to defraud – as does § 1347.[36]

Defendants do not contest that the jury was required to find that they acted with specific intent to defraud a health care benefit provider, or that the indictment adequately described the overall scheme to defraud health

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[33] *United States v. Gray*, 96 F.3d 769, 776 (5th Cir.1996).

[34] *United States v. Waymer*, 55 F.3d 564, 568 (11th Cir.1995) (holding that, as the bank fraud statute incorporates specific intent as an element, the defendant's vagueness challenge to the statute must fail).

[35] *Screws v. United States*, 325 U.S. 91, 102, 65 S.Ct. 1031, 89 L.Ed. 1495 (1945) ("But where the punishment imposed is only for an act knowingly done with the purpose of doing that which the statute prohibits, the accused cannot be said to suffer from lack of warning or knowledge that the act which he does is a violation of law. The requirement that the act must be willful or purposeful may not render certain, for all purposes, a statutory definition of the crime which is in some respects uncertain. But it does relieve the statute of the objection that it punishes without warning an offense of which the accused was unaware.").

[36] *Id.*, *United States v. Daniels*, 247 F.3d 598, 600 (5th Cir.2001). In *Daniels*, we concluded that there is nothing "inherently vague in the notion of a general anti-fraud statute." *Id.*

care benefit providers. Although the indictment itself may have been flawed, leaving defendants somewhat unsure which of the 13 listed executions of the scheme the government would attempt to prove at trial, neither the statute nor the indictment left defendants guessing at what conduct the government alleged was fraudulent, whom they defrauded, or how. Defendants' real objection appears to be the fact that the indictment did not separately charge each execution of their scheme to defraud health care benefit programs, which, as we observed above, it was not required to do. Defendants do not advance that they did not understand what it meant to execute the scheme to defraud and therefore could not have intentionally violated the statute. We hold that defendants' vagueness challenge to the constitutionality of the health care fraud statute fails.

C. Motion for Bill of Particulars

1. *Standard of Review*

We review denial of a motion for a bill of particulars for abuse of discretion.[37] Only defendant Murphy moved for a bill of particulars, however, so our review as to defendant Kirkham is for plain error.

2. *Bill of Particulars*

The purpose of a bill of particulars is to apprise a defendant of the charges against him with enough detail to allow him to prepare his defense.[38] A criminal defendant

[37] *United States v. Lavergne*, 805 F.2d 517, 520 (5th Cir.1986).

[38] *United States v. Montemayor*, 703 F.2d 109, 117 (5th Cir.1983).

must demonstrate that he was actually surprised at trial, and thereby prejudiced in his substantial rights, before we will reverse a conviction based on a district court's denial of a motion for a bill of particulars.[39]

As we concluded above, the indictment returned against Kirkham and Murphy was duplicitous; nevertheless, it gave defendants adequate notice of the charges against them. The language of the indictment clearly describes the essential elements of the crime and charges that defendants "knowingly and willfully executed, and attempted to execute, a scheme and artifice to defraud health care benefit programs . . . " This tracks the language of § 1347, which states "whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program,"[40] and makes clear which subsection of the statute defendants were being charged with violating. The indictment goes on to name six insurance companies that defendants allegedly defrauded, and, in seven paragraphs under Part B, the specific scheme or artifice by which defendants allegedly defrauded them. The time frame of the scheme, August 1996 through 2000, is also included. Part C of the indictment lists 13 allegedly fraudulent medical claims, including dates and the names of insurance providers, doctors, and patients, submitted by defendants in their

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[39] *Lavergne*, 805 F.2d at 521 ("The fact that the indictments are only thus decipherable falls short of the precision desirable in an indictment. But a finding that no bill of particulars was needed also rests on the fact appellants have not made the requisite showing of surprise . . .").

[40] 18 U.S.C. § 1347(1).

execution of the scheme.[41] The government obviously provided enough information to the defendants to give them notice of the charges against them.

In any event, Murphy (and, for that matter, Kirkham) was neither surprised nor prejudiced at trial by the court's failure to grant his motion for a bill of particulars. The government provided both defendants with voluminous discovery, including the testimony and exhibits eventually introduced against them at trial.[42] Moreover, even if the indictment had not furnished adequate information about the charges brought against defendants, the government's providing them with the necessary information in another satisfactory form obviated the need for a bill of particulars.[43] We are convinced that defendants were not actually taken by surprise at trial, so the trial court's denial of the bill of particulars did not prejudice them.[44]

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[41] Five of these claims listed Lostetter as the doctor who allegedly provided services to the patient; as noted *infra*, Lostetter was originally indicted along with Kirkham and Murphy but did not go to trial with them. Therefore, the government did not present evidence as to these transactions.

[42] *See Lavergne*, 805 F.2d at 521 (holding that defendants had not been surprised or prejudiced by facts used to support the government's case because the government had made the evidence used at trial available for inspection and copying by the defendants' attorneys or investigators).

[43] *United States v. Vasquez*, 867 F.2d 872, 874 (5th Cir.1989).

[44] *See United States v. Montemayor*, 703 F.2d 109, 117 (5th Cir.1983).

D. 404(b) Challenge

1. *Standard of Review*

We review challenges to the admission of evidence for abuse of discretion.[45]

2. *Extrinsic Evidence of Bad Acts*

Defendants challenge the trial court's admission of evidence of fraudulent transactions that were not specified in the indictment. They contend that these transactions constitute evidence of extrinsic bad acts, requiring the trial court to weigh the probative value of the evidence against unfair prejudice to the defendants as a result of its admission.[46] Defendants argue further that, as the government did not disclose its intention to introduce this evidence at trial pursuant to defendants' 404(b) motion to disclose, they did not receive fair notice that such evidence would be introduced against them at trial.

If the existence of a scheme to defraud is an element of the offense, then acts and transactions constituting a part of that continuing offense are admissible as proof of the criminal enterprise.[47] Evidence of an uncharged offense

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[45] *United States v. Stouffer*, 986 F.2d 916, 924 (5th Cir.1993) (citing *United States v. Liu*, 960 F.2d 449, 452 (5th Cir.1992)). Defendants made a 404(b) challenge only to the admission of the testimony of Lydia Roberts, a patient/client of the clinic; the trial court also admitted testimony of other patients and patient files not listed in the indictment, to which the defendants did not object. Although review of this other evidence should rightfully be for plain error, as we hold that the court did not abuse its discretion with respect to admission of any of the evidence at issue here, it obviously did not commit plain error either.

[46] *See United States v. Dula*, 989 F.2d 772, 777 (5th Cir.1993).

[47] *See id.* at 777-78.

arising out of a scheme or artifice to defraud is not "extrinsic" within the meaning of 404(b) and thus not excludable on this ground.[48] The prosecution may offer evidence of any surrounding circumstances that are relevant to prove intent or motive with respect to the fraudulent scheme.[49]

All the evidence challenged by Murphy and Kirkham concerned other transactions that tended to show the existence of the continuing scheme to defraud insurers. The evidence introduced by the government was undeniably relevant to proving defendants' intent or motive with respect to the fraudulent scheme. Most telling is the fact that defendants did receive fair notice of this evidence, as the government either produced or allowed defendants access to all of it well in advance of trial. The district court did not abuse its discretion in admitting this evidence.

E. Jury Instructions

1. *Standard of Review*

Appellants did not challenge the jury instructions at trial or proffer any alternative instructions of their own.

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[48] *Id. See also Stouffer,* 986 F.2d at 926 ("[E]vidence relevant to establish the existence of a criminal enterprise is not extrinsic to the crime charged."); *United States v. Lokey,* 945 F.2d 825, 834 (5th Cir.1991) (holding evidence of similar crimes committed outside the temporal scope and substantive counts of the indictment admissible "because it was relevant to establish how the conspiracy came about, how it was structured, and how each appellant became a member"); *United States v. Nichols,* 750 F.2d 1260, 1264-64 (5th Cir.1985) (holding evidence of defendant's involvement in uncharged crimes admissible as it was intrinsic to the government's case in proving the existence of a conspiracy).

[49] *Id.*

We therefore review their complaints about the instruction for plain error.[50]

2. *Contested Jury Instructions*

Defendants contest the trial court's instruction to the jury that it was not necessary for the government to prove "all the details alleged in the indictment concerning the precise nature and purpose of the alleged scheme." They take issue as well with the court's instruction that "it must be proven beyond a reasonable doubt that the defendants knowingly devised or intended to devise a scheme substantially similar to that charged in the indictment and that they executed or attempted to execute the same." These instructions, defendants argue, may have caused them to be found guilty of uncharged conduct or may have resulted in a non-unanimous verdict.

The government responds first by pointing out that the instructions at issue required the jury to convict only for conduct charged in the indictment. It acknowledges, however, that the indictment charged multiple executions

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[50] *United States v. Hickman*, 331 F.3d 439, 443 (5th Cir.2003), on remand at 282 F.Supp.2d 528 (S.D.Tex.2003), affirmed by 374 F.3d 275 (5th Cir.2004), vacated and remanded for re-sentencing in accordance with *United States v. Booker*, ___ U.S. ___, 125 S.Ct. 738, 160 L.Ed.2d 621 (2005), ___ U.S. ___, 125 S.Ct. 1043, 160 L.Ed.2d 1041 (2005). Defendants charge that to challenge the instructions would have been futile and refer us to *United States v. Velarde-Gomez*, 224 F.3d 1062, 1074 (9th Cir.2000), in which the Ninth Circuit allowed a "pointless formality" exception to the requirement for formal objections to jury instructions. This decision was vacated by an en banc re-hearing, 269 F.3d 1023 (9th Cir.2001). The Ninth Circuit's rule, established by other cases, requires that a defendant offer an alternative instruction, which the defendants in this case do not claim to have done. *See United States v. Kessi*, 868 F.2d 1097, 1102 (9th Cir.1989).

of a scheme in but a single count, and that this potentially posed a danger of a non-unanimous verdict. Conceding that a special unanimity instruction would have avoided this claimed problem with the indictment,[51] the government nevertheless contends that the court's general unanimity instruction ("Your verdict must be unanimous as to each defendant named in the indictment.") was sufficient. Citing our decision in *United States v. Tucker*, the government goes on to argue that, absent evidence to the contrary, a court has no reason to assume that a verdict is not unanimous.[52]

The government argues further that defendants have produced no evidence that they were prejudiced. The key issue at trial was whether defendants' business was a fraudulent scheme under § 1347. As there is no question that, if the business was fraudulent, defendants executed the fraud numerous times, argues the government, there is little danger that the jury convicted defendants non-unanimously.

Although the indictment was duplicitous and did create the potential risk of a non-unanimous verdict, the district court instructed the jury that it must find that defendants had executed or attempted to execute the fraudulent scheme. As we noted above in our discussion of defendants' challenge to the sufficiency of the evidence,

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[51] *See United States v. Baytank*, 934 F.2d 599, 609 (5th Cir.1991) ("[T]he complaint comes down to whether the jury instructions were sufficient, as it is clear that this aspect of a duplicity problem can be cured by appropriate special instructions which . . . inform the jury that it must unanimously agree on *the specific basis* . . . on which it finds the defendant guilty") (emphasis in original).

[52] 345 F.3d 320, 336 (5th Cir.2003).

there was ample evidence supporting the government's charges as to several of the executions of the scheme listed in the indictment, and there is no real danger that the jury did not agree that defendants had executed the scheme. Even if the district court might have erred in not giving a special unanimity instruction to cure the defect in the indictment, such omission did not prejudice defendants.[53]

F. *Ex Post Facto* Conduct

1. *Standard of Review*

Defendants did not raise this argument before the district court. We therefore review it for plain error.[54]

2. *Conduct Predating the Statute of Conviction*

Defendants argue that, by presenting evidence of their conduct that took place prior to the August 1996 effective date of § 1347, the government violated the Constitution's *Ex Post Facto* clause. In response the government emphasizes that (1) the indictment specified that the criminal scheme extended from August 1996 until 2000, (2) the only executions listed in the indictment took place after August 1996, and (3) the district court instructed the jury that it must find a scheme or plan to defraud "substantially the same as the one alleged in the indictment." Although the government did adduce evidence relating to pre-enactment

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[53] *See, e.g., Baytank*, 934 F.2d at 610 (holding no plain error where court did not give special unanimity instruction on single count, duplicitous indictment); *United States v. Razo-Leora*, 961 F.2d 1140, 1146-47 (5th Cir.1992) (finding no plain error despite trial court's failure to give special unanimity instruction on duplicitous indictment).

[54] *United States v. Richards*, 204 F.3d 177, 197 n. 6 (5th Cir.2000).

conduct, this evidence demonstrated the existence of a continuing offense and, as it was not listed in the indictment, could not have been the conduct for which the jury convicted defendants.

A law violates the *Ex Post Facto* clause if it punishes acts that, when committed, were not criminal.[55] In *Hickman*, we held invalid the defendant's conviction on three specific counts under § 1347 for violation of the *Ex Post Facto* clause.[56] Although we noted that a scheme to commit health care fraud is a continuing offense, we found that these three counts charged behavior that had been fully executed before the effective date of the statute.[57] With respect to continuing offenses in general, however, the *Ex Post Facto* clause is not violated by application of a statute to a continuing scheme that began before the effective date of a statute but continued thereafter.[58]

Unlike the *Hickman* indictment, the one-count indictment against Kirkham and Murphy did not charge them on or list any individual counts or executions of transactions that were fully executed before the effective date of the statute. In fact, all of the executions listed in the indictment involved transactions that took place well after August 1996, and each "patient" who testified at trial was billed after 1998. There is no danger that defendants were

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[55] *Hickman*, 331 F.3d at 445.

[56] 331 F.3d at 447.

[57] *Id.* at 447.

[58] *United States v. Duncan*, 42 F.3d 97, 104 (2d Cir.1994); *United States v. Garfinkel*, 29 F.3d 1253, 1259-60 (8th Cir.1994). *See also Hammen*, 977 F.2d at 385.

convicted on the basis of their pre-enactment behavior.[59] We hold that, as no *Ex Post Facto* violation occurred, the trial court did not err by admitting the evidence in question.

G. Calculating the Amount of Loss

Defendants also challenge the district court's sentencing calculation of the amount of loss caused by their fraudulent activity. To avoid an *Ex Post Facto* violation at sentencing, both defendants were sentenced under the 2000 edition of the United States Sentencing Guidelines ("U.S.S.G."). The court calculated a base offense level of six for a violation of § 1347 under former U.S.S.G. § 2F1.1(a) and adopted the intended-loss figures reported in defendants' Presentence Investigation Reports (PSR) in applying offense level enhancements under § 2F1.1.

Kirkham's PSR reported an intended loss of $6,654,634, resulting in a 14-level enhancement under § 2F1.1(b)(1)(O); Murphy's PSR reported an intended loss of $1,709,826, resulting in a 12-level enhancement under § 2F1.1(b)(1)(M). For its calculation of restitution, the district court adopted the actual loss amounts stated in defendants' respective PSRs, resulting in a restitution order of $2,751,270 for Kirkham and $732,061 for Murphy. Although the district court computed defendants' sentences by including various

[59] *See United States v. Todd*, 735 F.2d 146, 150 (5th Cir.1984) (holding that evidence of conduct occurring prior to enactment of criminal statute did not violate *ex post facto* clause because the indictment for conspiracy included only two overt acts that occurred prior to the effective date of the statute and most – but not all – of the evidence presented at trial focused on events that took place after the effective date.) In *Todd* we also relied on the fact that, as in the instant case, the record clearly established violations of the relevant statute *after* its effective date. *Id.*

other enhancements and adjustments, on appeal they challenge only the calculation of loss, intended and actual.

The Supreme Court's recent decision in *United States v. Booker* makes clear that imposition of a sentence based on facts found by the sentencing judge rather than by a jury or a confessing defendant, under a mandatory sentencing guidelines regime, violates a defendant's Sixth Amendment rights.[60] Under *Booker,* defendants clearly experienced such a violation of their constitutional rights when the trial court included in its loss calculations amounts not admitted by defendants or proved to the jury beyond a reasonable doubt.[61] We recently held, in *United States v. Mares,* that when a defendant has preserved his Sixth Amendment/*Booker* objection in the district court by an objection to his sentencing, we will ordinarily vacate and remand, unless we can say that the error is harmless under Rule 52(a) of the Federal Rules of Criminal Procedure.[62] Although neither *Booker* nor its earlier state-Guidelines analog, *Blakely v. Washington,*[63] had been decided at the time of defendants' sentencing hearings, we hold – and the government concedes – that objections made by defendants at their sentencing hearings were sufficient to invoke their Sixth Amendment rights to the extent necessary to preserve their *Booker* objections. We

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[60] ___ U.S. ___, 125 S.Ct. 738, 750-51, 160 L.Ed.2d 621 (2005).

[61] *See* 125 S.Ct. at 751, 769 (upholding circuit court's holding that, as the district court had applied the Guidelines as written and imposed a sentence higher than the maximum authorized solely by the jury's verdict, based on its finding that the defendant had possessed 566 grams of cocaine in addition to the 50 grams found by the jury, the defendant's Sixth Amendment rights had been violated).

[62] 402 F.3d 511, 520 n. 9 (5th Cir.2005).

[63] 542 U.S. 296, 124 S.Ct. 2531, 159 L.Ed.2d 403 (2004).

hold further that defendants have preserved this argument on appeal, as they briefed their challenge to the district court's calculation of loss using amounts not found by a jury, specifically citing *Blakely* in their reply briefs that were filed with us after *Blakely* was decided but before *Booker*.

Defendant Kirkham objected to the court's calculations by arguing that "[t]he loss, if any, must be proved in Court. The government never attempted to prove any dollar loss in this case. Therefore, any loss attributable to Kirkham must be restricted to that alleged in the indictment." Murphy made a similar objection to the court's calculations, stating that he objected "to the method of computing [his] punishment and fine or restitution without determining which scheme or attempted schemes were actually found by the jury to be executed." He went on to insist that he "may be punished only for conduct found by the jury to be fraudulent on the allegations in paragraph C in the indictment. . . ." Even though neither defendant expressly cited *Apprendi*, *Blakely*, or the Sixth Amendment in his objections at his sentencing hearing, we hold that the above-quoted language, challenging the district court's sentencing based on facts – the quantum of actual or intended loss – not found by a jury was sufficient to inform the district court that defendants objected to their sentences under the Sixth Amendment. They thereby preserved their *Booker* objections to the district court's calculation of loss.[64]

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[64] *See, e.g., United States v. Dowling*, 403 F.3d 1242, 1243-44, 2005 U.S.App. LEXIS 4725 at *7-13 (11th Cir.2005) (holding that, in order to preserve a *Booker* objection, a defendant must make a "constitutional" objection at sentencing, which may include citing *Apprendi*, the Sixth

(Continued on following page)

As we stated in *Mares*, we will ordinarily vacate a defendant's sentence when he has preserved an objection to a *Booker* Sixth Amendment violation and we find the violation not to be harmless error.[65] Rule 52(a) of the Federal Rules of Criminal Procedure provides that a harmless error is "any error, defect, irregularity or variance that does not affect substantial rights" and such error

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Amendment, or the defendant's right to have facts found by a jury instead of a judge); *United States v. Selwyn*, 398 F.3d 1064, 1066-67 (8th Cir.2005) (holding that defendant had preserved his Sixth Amendment challenge to his sentence by objecting to drug quantity findings at his sentencing hearing); *United States v. Fox*, 396 F.3d 1018, 1027 (8th Cir.2005) (finding that defendant had preserved his Sixth Amendment *Booker* objection to drug quantity finding by objecting to PSR's recommendation that he be found responsible for a greater quantity of methamphetamine than that for which the jury had convicted him). We requested supplemental briefing from both parties after publication of the Court's *Booker* decision and we note that the government also concedes that the defendants have preserved their *Booker* objections.

[65] 402 F.3d at 520 n. 9. We note, however, that the Court's *Booker* opinion appears to suggest that we engage in a harmless error analysis only in cases *not* involving a Sixth Amendment violation. *See* 125 S.Ct. at 769 ("[I]n cases *not involving a Sixth Amendment violation*, whether resentencing is warranted or whether it will instead be sufficient to review a sentence for reasonableness may depend upon application of the harmless-error doctrine.") (emphasis added). In cases involving particular constitutional violations, the Court has held that these defects "infect the entire trial process" and by their nature "necessarily render a trial fundamentally unfair," therefore obviating the need, once such a constitutional violation has been identified, for further analysis before reversing a defendant's sentence. *Neder v. United States*, 527 U.S. 1, 8, 119 S.Ct. 1827, 144 L.Ed.2d 35 (1999) (listing such errors as complete denial of counsel, trial before a biased judge, racial discrimination in selection of grand jury, denial of public trial, and defective reasonable-doubt instruction as errors requiring reversal of a defendant's conviction because of their inherent harmfulness). As the government does not argue that the trial court's error was harmless in this case, however, we decline to speculate whether such an analysis would be necessary under these circumstances.

"must be disregarded." When harm is in question, we must determine whether such an error is harmless beyond a reasonable doubt before we will vacate a defendant's sentence; unlike plain error analysis, the government, not the defendant, bears the burden of persuading us that an error did not affect the defendant's substantial rights.[66]

The government does not argue in this case that the district court's employment of the Sentencing Guidelines as mandatory did not affect defendants' substantial rights; rather, the government agrees that we must vacate defendants' sentences and remand for re-sentencing. We glean no indication from the record on appeal that the mandatory nature of the Guidelines and the facts found by the court rather than by the jury did not affect the length of defendants' sentences.[67] We therefore vacate their sentences and remand for re-sentencing.

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[66] *Neder*, 527 U.S. at 15; *United States v. Olano*, 507 U.S. 725, 734, 113 S.Ct. 1770, 123 L.Ed.2d 508 (1993) (noting that, unlike harmless error analysis, in which the government bears the burden of showing no prejudice to the defendant's rights, plain error analysis places this burden on the defendant); *United States v. Wheeler*, 322 F.3d 823, 828 (5th Cir.2003) ("Unlike the harmless error analysis, it is the defendant rather than the Government who bears the burden of persuasion with respect to prejudice.") (citing *Olano*, 507 U.S. at 734); *United States v. Tello*, 9 F.3d 1119, 1131 (5th Cir.1993) (stating that, as the party seeking to preserve the defendant's sentence under harmless error analysis, the government bears the burden of persuading the court that the district court would have imposed an identical sentence absent an erroneous application of the guidelines).

[67] *See United States v. Rogers*, 126 F.3d 655, 661 (5th Cir.1997) ("The misapplication of a guideline is harmless error if the district court would have imposed the same sentence even in the absence of the error. . . . The question is not whether the district court *could* have chosen the same sentence, but whether it *would* have chosen that sentence.") (emphasis in original).

III. CONCLUSION

Although the defendants' indictment was technically duplicitous, they waived this argument by not raising it before trial, and they have not suffered substantial prejudice to their rights as a result of the flawed indictment. Defendants have not shown that the district court erred or, if it did, that the error affected their substantial rights with respect to any of their other challenges to their conviction. We therefore affirm defendants' convictions.

Not so for their sentences. As defendants preserved their objections to the district court's calculation of loss under the sentencing guidelines, and the district court's use of facts that were neither admitted by the defendants nor found by the jury in determining defendants' sentences under the mandatory sentencing guidelines violated defendants' Sixth Amendment rights, their substantial rights were affected as a matter of law. We therefore vacate defendants' sentences and remand this case to the district court for re-sentencing.

CONVICTIONS AFFIRMED; SENTENCES VACATED AND CASE REMANDED FOR RE-SENTENCING.